



The
University
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**REPRODUCTIVE HEALTH POLICY FORMULATION AND IMPLEMENTATION IN GHANA:
THE ROLE OF WOMEN'S RIGHTS ADVOCACY GROUPS**

NANCY ANSAH

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ABSTRACT

Research and policy debates suggest women's rights advocacy groups have been significant in generating important social policy changes. However, in the West African context there are major gaps in research about the activities and impacts of women's rights advocacy groups. In particular, there is little in-depth qualitative research about the perspectives and experiences of women's rights advocates in this context; and, more specifically, about how they perceive, practice and evaluate their roles, actions and collaborations. To address these gaps, this study examined women's rights advocacy in the field of reproductive health and promoting healthcare policies and provisions in Ghana from insider perspectives. A pertinent issue in this context is how violence against women affects women's reproductive health which constituted a key dimension to this study.

The study adopts a qualitative framework to enable participants to share their experiences as they construct their roles in the policy-making process. In total 25 semi-structured interviews were conducted with participants including leaders of women's rights advocacy groups, policy-makers, and UN workers. The findings indicate that women's rights advocacy groups constructed their roles as achieving policy and social change. Their activities span problem and solution framing, legislative drafting, promoting the adoption of legislative instruments, holding the state accountable, and monitoring the implementation of policies. Further, framings of gender inequality, evidence-based advocacy and coalition-building were central to the advancement of their political activities. The study found evidence that key motivations for advocates were toward the benefit of disadvantaged groups in society. The study found women's rights advocacy groups often sought recognition that reproductive health is a social good. The data indicated coalition dynamics and funding sources were challenges for advocacy actions. Recommendations for policy learning are made on grassroots participation in advocacy, the need for robust data, and sustained funding for women's rights advocacy groups.

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CHAPTER 1: BACKGROUND AND RATIONALE OF THE RESEARCH

1.0 Introduction

This thesis aims to explore how those involved and leading advocacy groups in Ghana perceive and understand their engagement and their impact on the social policy-making process to influence policy formulation and implementation. The qualitative research has a particular focus on advocacy activities on women's sexual reproductive health and rights, paying particular attention to violence against women and its impact on women's reproductive health. The 1994 International Conference on Population and Development (ICPD) in Cairo resulted in important changes in Ghana's Reproductive health policy from a population-oriented policy to a health-centred policy. One of the key results of the conference was finalising the new Reproductive Health Policy and standards in 2003. The policy defines reproductive health as:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters related to the reproductive system and its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so (Republic of Ghana, 2014, p.2).

The right to information and access to safe, affordable, and acceptable family planning methods is implicit in the above definition. Statistics however show that many women are not able to adequately enjoy these services and rights to ensure their ultimate well-being. The Ghana Maternal Health Survey (2007) states that maternal mortality is the second largest cause of deaths among females. A high number of deaths was reported during pregnancy, then delivery, and the post-partum period. 12 Ghanaian children die before reaching age 5. Fertility rate is high especially among rural women as young mothers are also common. High knowledge of contraceptives does not translate into use of modern contraceptives. Women constitute 66% of people living with HIV in Ghana highlighting inequality that leads to unsafe sex practices.

Sexual and reproductive health also include issues of determinates of health such as gender, poverty, and education (Shaw, 2009). Many of these social determinants are also articulated as rights (Shaw, 2009). Adanu et al. (2012) in their research to explore the burden of sexual and reproductive ill-health among women in Accra (the capital city of Ghana) found that the majority (64.8%) of their sampled population indicated they were self-employed. The self-employed women were mostly in informal employment such as selling at the local markets. Against this background is the fact that though reproductive health services

are largely covered by the National Health Insurance, in practice, pregnant women registered under the NHIS still must pay for some services (Adanu *et al.*, 2012).

It has been found that gender-based violence is one of the key determinants of the quality of women's reproductive health (Yeboah and Batse, 2009). Violence against women is defined broadly by the World Health Organisation (WHO) as:

Any act of gender-based violence that results or is likely to result in physical, sexual, or psychological harm or suffering to women including the threat of such acts, coercion, or arbitrary deprivation of liberty whether occurring in public or private life (Statistical Service, 2013, p.28; World Health Organisation, 2016).

Violence against women affects women's ability to access reproductive health services and their ability to enjoy safe sex. Violence against women is rooted in Ghanaian societies. In 1999, the Gender Studies and Human Rights Documentation Centre conducted a national-level study involving 1588 women and 481 girls. The research revealed that only 12.3% of respondents had not experienced any type of sexual, physical, or psychological violence (Yeboah and Batse, 2009). Societal norms that require women and girls to be ignorant and passive sex participants affect women's reproductive health negatively. Decisions on when, how and with whom, to have sex is largely taken by men. The age difference between young women and their partners in Sub-Saharan Africa and for that matter in Ghana, increases the gender power imbalance and it is a major determinant of the spread of HIV and violence (Shaw, 2009). Poverty also leads to transactional sex often as a desperate need, or through those in positions of power.

Though Ghana is a signatory to many international conventions and treaties which stipulate the reproductive health rights of women and also has national policies on sexual reproductive health and rights, there are still huge gaps in policies and their implementation. This implies that the reproductive health and rights of women are not adequately guaranteed. Rights to body integrity, right to make informed choices on sexual partner, equality of marriage and divorce and to be free from sexual based violence of all forms are integral part of reproductive health (Shaw, 2009).

Delivery of timely and rights-based services need effective legislation and policies. In this regard, advocacy by women's rights groups is key in pressing demand for government to develop policies that are needed and ensure that reproductive health services are delivered, and the rights of women are protected. In this research advocacy is when organisations/groups generate pressure on the state and other decision-makers (government policy actors) on clearly defined problems to formulate social policies or effect policy changes and ensure effective implementation of those policies (Lustig, 2012). Organisations that pursue such policy-related activities and who work on issues related to women's human rights are referred to as women's rights advocacy groups in this research. All the groups in this research are non-governmental organisations. Policy actors that women's rights advocacy groups interact with during their advocacy activities include individuals, institutions and networks who take policy decisions or have considerable interest and influence on shaping social policy outcomes (Kingdon, 2011).

1.1 The Role of Women's Rights Advocacy Groups

The structural extent of gender inequality means most nation-states do not typically adopt feminist changes without pressure from organised groups of women (Viterna and Fallon, 2008). As a women's rights advocate, I am aware that women's rights advocacy groups are very active in pushing for policy and legal changes in reproductive health service delivery and rights as well as violence against women to improve the reproductive health and rights of women and eradicate violence against women. Adomako Ampofo (2008) opines that women's movements organised around gender issues are one of the most mobilised social and political actions/actors in recent times. However, my observations and experience (as a women's rights advocacy practitioner) and from the literature review about women's rights advocacy groups in Ghana, indicate that there is inadequate research on advocacy by women's rights groups who work in the area of reproductive health and violence against women and there is also minimal understanding about how individuals active in the process and policy area perceive, experience and practise their desired and actual influence on politics, policy and services. The link between violence against women and women's reproductive health is also not explicit enough in women's advocacy activities and subsequently the documentation of these activities though violence is one of the key determinants of women's reproductive health.

The objectives of this research are therefore to:

- Examine how those involved in leading and practising women's rights advocacy perceive and experience their roles and actions within all phases of the policy process.

- Explore how those involved in reproductive health and violence against women advocacy act as individuals, members of organisations and members of coalitions throughout the policy process.

1.2 The Research

The two main questions addressed by the research are:

- How and why do women's rights advocacy groups and other policy actors conceptualise and frame the relationship between women's rights, gender inequality, violence against women and reproductive health rights in the Ghanaian context?
- Analysing the perspectives and experiences of women's rights advocacy groups and other policy actors, how do they pursue and practice advocacy in this area? And what influences effectiveness and impact?

The sub questions are:

- How do women's rights advocacy groups conceptualise and evidence the relationship between violence against women and women's reproductive health during the advocacy processes?
- How do women's rights advocacy groups construct and frame the problems of inadequate reproductive health rights and services and violence against women; and the proposed/preferable policy changes and alternatives?
- From the perspectives and experiences of women's rights advocacy groups and policy-makers, how do resources, relationships and context influence the advocacy process and impact?
- What are the tactics/strategies used to achieve advocacy outcomes?

The research employed a qualitative method in its approach and hence interviewed 16 leaders of women's rights advocacy groups, 6 policy-makers, and 3 UN workers. Initially, a qualitative-led mixed methods approach combining a social survey and semi-structured interviews was the research design. The survey would target 60 leaders of women's rights advocacy groups and seek to generate larger scale quantitative data about organisational characteristics, leadership, the budgets of their activities, advocacy campaigns they pursue, aims of the campaigns and the groups role in agenda-setting. However, challenges in recruiting respondents led to abandoning the quantitative approach to maintain the qualitative approach only. The qualitative approach had been the major method and was considered adequate for the research. Adomako Ampofo et al. (2008) confirm that African gender scholars regard qualitative approaches (interviews and stories) as more relevant to their experiences and the realities they are accustomed to. This research used qualitative research methods because it provided and allowed for an in-depth insider picture and to

conceptualise/theorise around the themes. The qualitative research method is rooted in the philosophies of interpretivism, constructionism and feminist standpoint - with the former particularly pertinent to my research. Interpretivism is based on the idea that social interaction is based on 3 principles; consciousness, actions, and unpredictability, and that society does not exist in an objective, observable form but rather is experienced subjectively because how people behave and perceive things give meaning to that phenomenon (Petty *et al.* 2012). Examining the meanings and interpretations of advocates and policy actors allowed better understanding of the policy process, policy change and the role and impact of advocates in this context.

The uniqueness of this research is the fusing of violence into reproductive health discourse and the fusing of gender inequality and policy theories (agenda-setting) to provide a framework for the analysis of women's reproductive health in Ghana.

1.3 Chapter Structure of the Thesis

The research is divided into 8 chapters. Chapters two and three are literature review chapters. Chapter two is the review of literature on the political and socio-economic context of Ghana, the health system, health care, and health reforms in Ghana. It also includes a review of key policies and laws on reproductive health and violence against women. This chapter of the literature review provides contextual background to women's reproductive health and violence against women in Ghana. The key policies reviewed included policies on reproductive health, policies on violence against women, and laws including the constitution of Ghana which sets out broad human rights of Ghanaians including their right to healthcare. Key international conventions on the rights of women and children were also reviewed as they provide a basis for many country-based policies in study. Literature on violence against women situated in feminist theory and literature are also reviewed. Feminist studies have been presented in the literature review as providing the best theoretical framework for understanding how violence impacts women's reproductive health in Ghana. Chapter three is the review of literature on the policy-making process, health policy as social policy, policy actors and institutions. The theories of agenda-setting by Kingdon (1984) and the Advocacy Coalition Framework (ACF) by Paul Sabatier and Hank Jenkins-Smith (Jenkins-Smith *et al.*, 2018) and later clarified by Sabatier and Weible (Nowlin, 2011) are reviewed as the main theoretical frameworks on the policy process through which this thesis is analysed. Literature on women's rights advocacy, and women's rights advocacy groups are also reviewed. This literature review postulates that women's advocacy groups are major platforms for the promotion of women's rights in the contemporary socio-economic and political context in Ghana.

The methodology of the research is explained in chapter four. The aims and objectives of the study as well as the research questions that guide the study are outlined. It also outlines the epistemological stands of the design and how that influences the choice of qualitative method for the research, emphasising that interpretivism, constructionism and feminist standpoint allow the study methods to be value-driven and includes the world view of the researcher. These stands influence the selection of methods of data collection and analysis. Qualitative data collection including a sampling of the 3 categories of participants (leaders of women's rights advocacy groups, policy-makers, and UN workers) were selected, design of 2 interview guides and how they were administered especially booking appointments for interviews and the interview duration, interview procedure challenges and adaptation in the field are discussed in detail. The chapter also explains why a planned mixed method approach was abandoned for qualitative research. The researcher's reflections on the impact of her position as an "insider" and the fact that her experiences and knowledge affect the research are also discussed. The awareness of these guides her throughout the research. The chapter also includes ethical considerations during data collection and analysis, ensuring anonymity of sampled participants, informed consent, and confidentiality. The chapter presents the 'how' of the data analysis and demonstrates the use of Nvivo to analyse qualitative data.

Chapters five, six and seven are the data analysis chapters. As the first of three qualitative data findings chapters, chapter five explores the perspectives and experiences of women's rights advocacy groups on reproductive health policy-making and implementation in Ghana and the link between violence against women and reproductive health. It examines how participants construct their role in the reproductive health policy-making process in Ghana and how violence against women, is a determinant of women's reproductive health. Utilising theories and concepts about multi-level governance and the stages of the policy process, the chapter examines the meaning of advocacy as achieving policy and social change and monitoring resource allocation at the levels of the state. The analysis of levels of power and the targets of the various levels (national, regional, district, and even international) and various systems and actors give credence to the importance of working from both sides as particular issues demand. The discussion of the data on the levels of advocacy also highlighted the top-down, bottom-up approach to policy-making. A bottom-up approach to policy-making is recognised by the women's rights advocacy groups as they apply their advocacy along those lines to be able to achieve their goals. Chapter six, through the agenda-setting theory and the feminist theory of gender inequality, explored how the advocacy groups of this study strategically framed their issues to achieve their goals and the strategies used in reaching policy-makers and other target audiences. The use of media as a strategy was also discussed, exploring the avenues for social

media use and its implication for future research by women's rights advocacy groups. Chapter seven, the last of the findings chapters, discussed through the Advocacy Coalition Framework and the concept of policy entrepreneurship, coalition-building and its importance to the advocacy process. It examined the nature and size of coalitions, the advantages of coalitions, the dynamics of the coalition process, and its impact on women's rights advocacy. Funding of advocacy activities in Ghana was also discussed, demonstrating that in recent times, funding for women's rights advocacy activities is difficult. The discussion also revealed the reasons behind the lack of funds, and how women's rights advocates, as policy entrepreneurs, creatively ensure continuity of funding for their advocacy process. The domination of international donors, emphasises the role the international community plays in funding reproductive health activities in Ghana and its impact on advocacy.

Chapter eight both concludes and draws together the three findings chapters. There is also reflection on the methodology, the limitations, the contribution to knowledge of this thesis and suggestions for future research in the domain of the study. The application of the research for policy purposes based on the findings of this thesis are also made.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

As the introduction chapter set out, this thesis aims to explore how advocacy groups engage in the social policy-making process to influence policy formulation and implementation on women's reproductive health, paying particular attention to violence against women and its impact on women's reproductive health. This chapter is the first of the two literature review chapters. The chapter provides an overview of the socio-economic context of Ghana including the population, employment, especially women, and work, Sexual Reproductive Health and Rights (SRHR) statistics are also provided (maternal health, abortion, HIV, and STIs). These Statistical trends are provided to situate the thesis in the political, economic, and social context to give meaning to the discussions that will emanate from the data. The SRHR statistics are directly linked to the research. They provide knowledge of the existing SRHR situation and hence the reasons for the various advocacy activities of women's rights advocacy groups. They provide the context of what claims the research participants may make or unmake. The relevant policies on reproductive health and violence against women are discussed, interlaced with history. The role of the United Nations and other international bodies in sexual reproductive health policies and financing of the health system are outlined in this section. The various policies reviewed are suggestive of the policy environment that the respondents of this thesis operate. The Ghana healthcare system is also briefly discussed, demonstrating the policy and administrative system women's rights advocacy groups operate within.

Again, the chapter focuses on violence against women and situates it in the feminist theory of gender inequality. It provides a critical review of the background and relevant empirical and theoretical literature. It indicates how feminist literature provides fundamental empirical and theoretical frameworks for researching and addressing how violence affects women's reproductive health in Ghana. The literature on gender inequality provides a framework for discussing the challenges to women's access to Sexual Reproductive Health and Rights and services. Indicators of violence, the laws of Ghana and violence, women and access to economic facilities, women and political representation, women and property rights, and women and body ownership are reviewed in detail to highlight the existing inequalities and provide grounds for the need for this research.

The literature review chapters draw on studies and theories, constructing a conceptual framework which guided questions and lines of inquiry in the thesis, identifying debates, limitations and the gaps in literature that the study fills.

2.1 Ghana: The Broader Context and Reproductive Health Indicators

2.1.1 Socio-Economic and Political Context since 1980

The Republic of Ghana is located in West Africa and it was the first Sub-Saharan African country to gain independence from British rule in 1957, following over 200 years of colonialism. With a significant population increase in recent decades, the national population stood at 24,658,823 in the 2010 National Population Census, an increase of around 31% compared to 2000 census figures (Ghana Statistical Service, 2013, p.50). In 2010, females represented 51.2% of the population (Ghana Statistical Service, 2012, pp2). The World Bank (2020) data indicates that the population of Ghana is currently 30,417, 856. The female population is 14,682, 873 representing 49.3%, a decline of 1.9% from the 2010 population census. Ages 0-14 constitute 37.3%, of the population, age 15-64 make up 59.3% and age 65 and above constitute 3% (The World Bank, 2020).

The tradition whereby families prefer to educate their sons rather than their daughters is decreasing and the educational gap between males and females is narrowing. Primary school enrolment (ages 6-11) reported by the Ghana Education Service was 86.16% in 2019 (Ghana Education Service, 2020). The introduction of the free senior high school policy has however increased enrolment in secondary schools (age 15 and above) by 17% in 2017 and 31% in 2018 (Tamanja and Pajibo, 2019). Data by Trade Economics (2020) shows that Secondary enrolment for 2019 was 64.57% and that 57.88% of them were girls. Despite the improvement in school enrolment, gendered ideologies and inequalities that generate competing pressures on young women lead to higher female drop-out rates at every level of the educational ladder compared to young men (The Borgen Project, 2018).

The economy of Ghana has improved significantly in recent decades. The Ghana Statistical Service (2018) provides that the annual Gross Domestic Product (GDP) growth rates recorded from 2005 to 2017 ranged from 3.7% to 14.0%. The highest growth rate was recorded in 2011 and the lowest was in 2016. Though the service sector has overtaken the agricultural sector as the highest GDP contributor, the agriculture sector continues to employ about 45% of Ghanaians and the majority of them work in the informal sector which is poorly regulated (Osei Boateng and Ampratwum, 2011). Irrespective of the fair GDP growth, national

poverty rates¹ are still high; around 23.4% of the general population (Ghana Statistical Service, 2018), women being in the majority. According to the Ghana National Living Standard Survey Round 6 report (Ghana Statistical Service (GSS), 2015), 77.1% of the adult population (aged 15 and above) are economically active. Seventy-nine per cent of men are economically active compared to 74.9% of women. The Ghana Statistical Service report (2013) states that 73.8% of women earn less than their husbands, which reflects and reinforces their subordination to men. Over the past decade, however, the government of Ghana has implemented various economic and poverty-reduction programmes (Ghana Statistical Service et al 2015).

2.1.2 Governance and Administration of Justice

Ghana is a constitutional democracy with a multi-party system of government (Oppong, Oppong and Odotei, 2006). The executive President is elected for a term of four years for a maximum of two terms and he is supported by a Vice President. Members of the executive are drawn from the largest political party in parliament, which by virtue of its majority has won an electoral mandate to govern. The Executive also benefits from three key advisory bodies including the National Development Planning Commission, the National Security Council, and the Council of State. All these bodies serve to counsel the government, and ensure it is functioning effectively.

The Unicameral parliament is also elected for a period of four years. As set out in the constitution of the Republic of Ghana (1992), parliament is the legislative body of Government. The Legislature is responsible for making laws. According to Friedrich Ebert Stiftung Foundation (2011), the government produces policies, and because it has majority in parliamentary votes, it dominates proceedings and usually gets approval for its policies. In 2016, women formed 13% of the elected members of parliament (the legislature), a slight increase from 11% in the 2012 elections (Madsen, 2018). There are ministers of state appointed by the President with approval of Parliament who head various ministries with specific functions. Out of the Ministers of State, the President, appoints a cabinet of about 19 members who assist him and his Vice President with government functions. In 2016, out of 19 cabinet ministers, only 4 were women representing 21% (Bauer 2019). There is low representation of women in politics though Ghana is a signatory to CEDAW

¹ In Ghana, the poverty line is calculated based on the analysis of consumption of food and non-food items of an individual which classifies the poor as those who lack command over basic consumption needs. In Ghana, the practice is to develop two poverty lines: the upper poverty line (which is referred to as the poverty line) and the lower poverty line (which is referred to as the extreme poverty line).

(Convention of the Elimination of All Kinds of Discrimination Against Women), the Beijing Platform for Action, the African Charter on Human and People's Rights, and the Maputo Protocol (Madsen, 2018).

During colonial rule, the institution of chieftaincy which is the traditional authority (including chiefs and queen mothers) ran parallel with the central government but after independence, they are not actively involved in the politics of the nation (Owusu-Mensah, 2013). Contrary to claims that the power of the chiefs in modern Ghana is limited, they still wield a lot of influence as traditional authorities regarded as custodians of the customs and traditions of their people (Owusu-Mensah, 2013).

The judicial system is modelled after the English judicial systems, and it recognises both customary and English common law. Justice is administered on two levels, the lower courts (district and circuit) and the superior courts (the Supreme Court, the Court of Appeal, and the High Court). There are also special courts and bodies including the Commission on Human Rights and Administrative Justice (CHRAJ). CHRAJ is a constitutional provision, and it is also backed by an enabling Act of Parliament, Act 456 of 1993 (The 1992 Constitution of the Republic of Ghana, 1993). It is established to protect fundamental human rights. This includes violations of the rights of women and children (Crook, Asante and Brobbey, 2011). The mandate of CHRAJ encompasses "investigating complaints of violations of fundamental rights and freedoms, injustice, corruption, abuse of power and unfair treatment of any person by a public officer in the exercise of his/her official duties" (The 1992 Constitution of the Republic of Ghana, 1993). In addition, it investigates complaints and actions by persons, and institutions on human rights violations. Though CHRAJ is criticised as being unable to implement some of its recommendations, Asibuo (no date) states that the Commission has successfully carried out its functions since its establishment in 1993. In 2015 there were 69 women out of 268 judges representing 20% of judges (Anaman and Armah, 2015). The traditional systems of adjudicating cases at the chieftaincy level and at the various family head level is still prevalent as they are easily accessible by citizens.

Administratively, Ghana is divided into 16 regions, each region is divided into districts, and districts are further divided into sub-districts. The delivery of social services, including reproductive health services, follows this decentralized system (Mayhew, 2003). Since 1992, the National Democratic Congress, a social democratic political party, and the New Patriotic Party (NPP), a liberal democratic political party have dominated national politics and formed governments in turn. The NPP has been ruling since January. The interest of citizens in governance is high and there is a high voter turnout during elections. For instance, France 24 (2020) reported on their website that 79% of registered voters in the 2020 elections voted.

2.1.3 Ethnicity and Culture

According to official categories used for census purposes and which also concur with everyday identity, Ghana consists of about 8 major ethnic/cultural groups: Akan, Ewe, Ga-Dangme, Mole Dagbani, Gurma, Guan, Grusi, Mande, and several additional smaller groups and identities (Ghana Statistical Service, 2013). To a significant degree, each ethnic group has its distinct culture and traditions such as systems of inheritance, marriage, and related rites. For example, some groups have patrilineal systems of inheritance and others have matrilineal systems of inheritance. In matrilineal systems, inheritance is passed on to male children of maternal sisters and in patrilineal systems, inheritance is passed on to male children. However, whether the system is matrilineal or patrilineal, it can strongly be argued that social structures and systems in Ghana across ethnic groups are highly patriarchal, a central issue returned to in this section. Christianity is the dominant religion with about 71 per cent of followers. The rest comprise Muslims, African Traditional Religion adherents, and other religions. A small number of citizens in official surveys do not identify with any organised religion or specific religious beliefs (GSS, 2012, p.6).

2.2 Reproductive Health Indicators

Maternal health is one of the most critical aspects of reproductive health because, during pregnancy and post-natal, women can experience many health and healthcare issues which, if not prevented, diagnosed, and treated, can lead to the death of mother and child. The Ghana Maternal Health Survey 2007, the first nationally representative survey to collect comprehensive information on maternal morbidity and mortality in the country, reliably reported that the maternal mortality ratio (MMR)² of the country in 2002 was 378 deaths/100,000 live births (Ghana Statistical Service, 2009, p.33). This represents a decrease of about 50% from the 1990s ratio of about 740 deaths/100,000 live births (Ghana Statistical Service, 2015) but it reflects trends in maternal mortality rates in Sub-Saharan Africa that are the highest in the world. The above data is unacceptable compared to average MMR rates below 20/100,000 births in Western European and other rich countries: and 60/100,000 births in Eastern Europe, Central Asia, and other regions in Latin America (Hogan *et al.*, 2011, p.614-1618)³.

² Maternal mortality ratio in Ghana was calculated from maternal deaths identified among 240,000 households sampled in a survey that identified deaths in women age 12-49 years (Ghana Statistical Service et 2014).

³ Hogan et al constructed a database of 2651 observations of maternal mortality in 181 countries between 1980-2008. This was done from vital registration data census, surveys and verbal autopsy studies. They used robust analytical methods in generating estimates for MMR.

The Ghana Health Service reports that unsafe abortions are the leading cause of maternal mortality in Ghana with data indicating that 13% of women who have unsafe abortions, die following the procedure (Ghana Statistical Service and Ghana Health Service, 2009). In a recent study that asked women for their reasons for having an abortion, the main reasons provided were lack of money to cater for pregnancy and child - highlighting the significance of poverty and economic disadvantage (Ghana Statistical Service and Ghana Health Service, 2009). In 1985 Ghana liberalized abortion laws to permit abortion for the following reasons: incest, to save the life of the mother, rape, protection of the mental and physical health of the mother, and also on the ground of fetus abnormalities. However, irrespective of the change in the abortion laws, Rominski et al (2014) in their study on female autonomy and reported abortion seeking in Ghana, found that women faced barriers in accessing safe services including a lack of awareness about their legal rights, lack of money to pay for the cost of services and stigma associated with abortion due to cultural and religious beliefs.

According to the United Nations Population Fund (2020), the national fertility rate in 2019 was 3.89 which was slightly higher than the 3.8 recorded in 2015 and the rate of use of contraceptives increased from 17% in 2008 to 27% in 2020. Though there is a high unmet need for family planning, there are factors that impede the uptake of family planning. Apanga and Adam (2015) in a cross-sectional study of 280 residents of childbearing age of the Talensi district in Ghana (predominantly rural communities), found out that the factors influencing the low intake of family planning include low awareness of the availability of family planning methods, husbands' opposition against their wives using family planning services, women not being properly informed of the various methods, and inadequate counselling by service providers and religious inclinations.

HIV rates are relatively average in Ghana. According to the Ghana AIDS Commission the adult (age 15 and above) HIV prevalence rate for 2019 stood at 1.7 per cent and women made up 66% of this population (<https://www.ghanaidc.gov.gh/>)⁴. The number of Persons Living with HIV (PLHIV) with suppressed viral⁵ load in 2019 was 45,739, a significant increase from 26,083 in 2018 (Ghana AIDS Commission, 2020).

⁴ HIV prevalence is calculated from a surveillance that collects HIV prevalence in Ghana and is calculated from data collected on HIV infection among pregnant women attending ante-natal clinic for the first time of the current pregnancy, using the unlinked anonymous method. The collection takes place in 22 sites, 2 in each region, plus two Sexually Transmitted Infections (STIs) sites within 8-10 weeks each year. The average prevalence from the sites within each region are calculated to represent an estimated prevalence in the region. The regional estimates, with data on population of regions are used to calculate national HIV prevalence.

⁵ Viral suppressing means when antiretroviral therapy (ART) reduces a person's **viral load (HIV RNA)** to an undetectable level.

Anti-retroviral therapy (ART) Coverage was 45% (UNAIDS 2020). This implies that about 55% of PLHIV are not accessing ART. In 2019, mothers needing Prevention of Mother-to-Child-Transmission (PMTCT) services were estimated at 15,900 but about 11,800 received services leaving a gap of about 3,900 pregnant women not accessing PMTCT services. This means the likelihood of 3,900 children being born HIV positive is high (Ghana AIDS Commission, 2020).

2.2.1 The Ghana Health System and the Concept of Quality of Care

Having discussed the reproductive health indicators in Ghana, this section provides a review of the healthcare system in Ghana. The administrative arrangement, service delivery, and professional skills available are reviewed. The review includes both public and private healthcare providers.

The Ghana Health System

According to the African Region Health Report (2013, p.106), “a health system can be defined as “all actors, organisations, institutions, and resources whose primary purpose is to improve health.” Promotion of health, restoration of health, and maintenance of health are the ingredients of improving health. Patients, healthcare providers, regulators, leaders and managers, politicians, funding schemes, health partners, religious leaders, CSOs, training institutions, and the media are all actors in the health system. In Ghana, health partners include international organisations like the United Nations (UNAIDS, UNFPA, and UNICEF) because they influence health policy-making and implementation in the country. Donor/development partners including USAID, UKAid, the Global Fund, DANIDA, and many other donors play key funding roles in the delivery of services.

The Ghana Health system is administered on three levels: national, regional, and district levels. However, functionally there are two more levels: the sub-district and the community level (Ghana Health Service, 2021). The Ministry of Health is the agency in charge of policy-making, resource mobilization, monitoring, and evaluation of the healthcare system (Atun et al., 2011). The Ghana Health Service is an executing agency of the Ministry of Health with the responsibility to run a decentralized health service to provide health care to Ghanaians (Agyepong, 1999). It was established under the law ‘ACT 525’ of 1996. It is under the Minister of Health, and it leads the implementation of national health policies (Odoi-Agyarko, 2003). Reproductive health services are under the Director of Reproductive and Child Health department within the Family Health division of the Ministry of Health (Ghana Health Service, 2021). Major programme areas include child health, family planning, safe motherhood, and newborn care (Odoi-Agyarko, 2003).

There are three sectors of healthcare service delivery: public sector health services, private-not-for-profit, and private-for-profit. Health services in the public sector are organised in a 4-prong approach; primary health care, secondary health care, tertiary health care, and quaternary care. Primary health care includes Community-based Health Planning and Services CHPS, health centres, and polyclinics, which are larger versions of community health centres, maternity homes, and chemical shops (*Abor et al.*, 2011). The chemical shops are licensed to retail only over-the-counter medicines. Secondary health care is provided at the district and regional hospitals, providing specialized in-patient care. The secondary level facilities provide referral services to tertiary care facilities. The tertiary hospitals are at the apex of the referral system, providing advanced specialized and quaternary care: in-patient, palliative care, plastic surgery, cardiac surgery, research, and training (*Osei et al.*, 2005). According to Sasu (2022) government hospitals in Ghana were 1625, quasi government hospitals numbered 79 and private hospitals comprising CHAG and other private for-profit and not-for-profit facilities numbered 225 in 2020.

THE HEALTH CARE SYSTEM IN GHANA

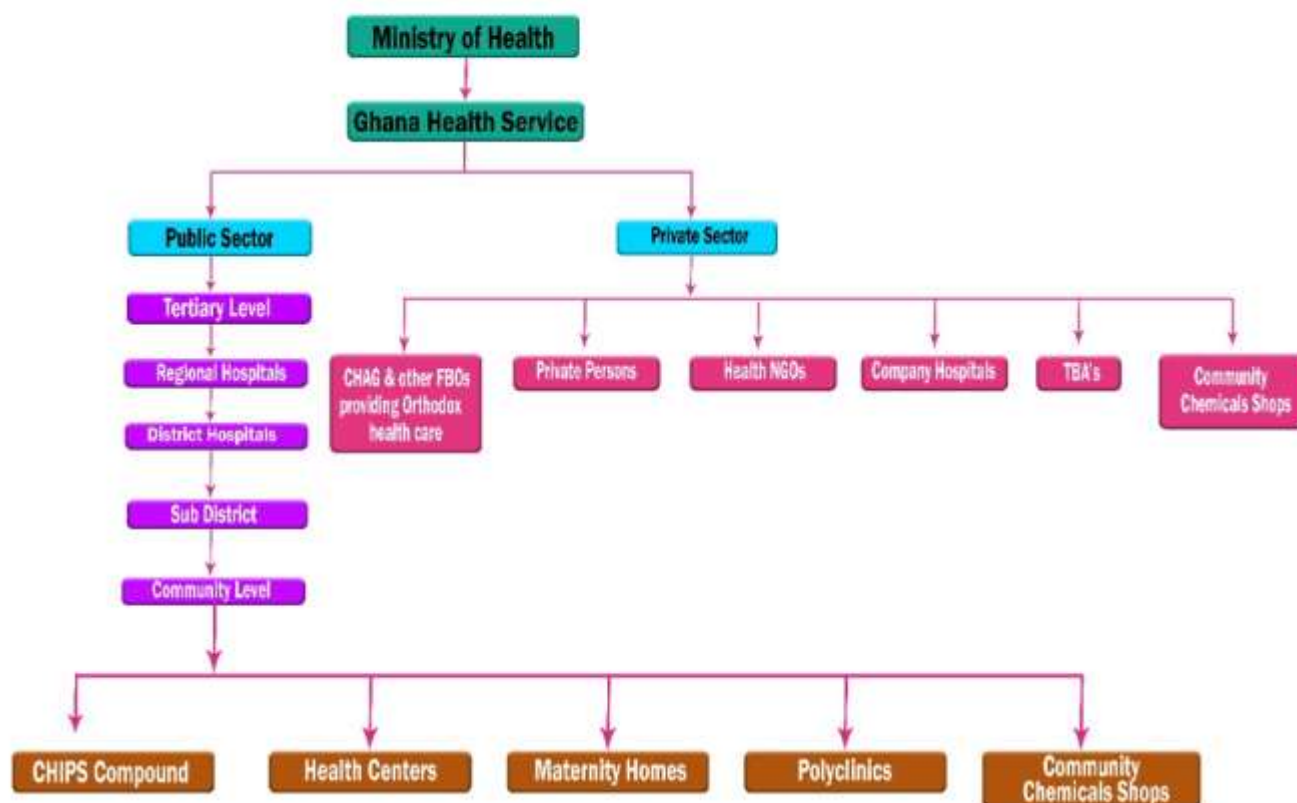


Figure 2.1: The Health Care System in Ghana

Administratively, reproductive health services are delivered through the decentralized system where decision-making, and management of health care are transferred to the regions and the districts. Mayhew (2003) however asserts that the centre remains strong as the Ministry of Health retains policy-making powers and contracts services to the Ghana health service, teaching hospitals, and non-governmental providers.

Regional hospitals manage high-risk pregnancies, and advanced clinical and diagnostic care; arrange logistics and technical backup for epidemiological surveillance and oversee research and training. They are also referral points for advanced diseases (Agyepong, 1999). District hospitals provide maternity services, referral care support to sub-districts in disease prevention and control, health promotion, and training and supervision of professionals and services in community health centres. The district hospitals also provide ante-natal services, supervised delivery by midwives, family planning and basic curative care, and deal with complications, and emergencies (Agyepong, 1999). Health centres and clinics at the sub-district levels provide basic curative care, disease prevention services, and maternity services (primary health care). There are three government psychiatric hospitals, 123 mental health out-patient services, and 7 community-based service centres (Roberts, Morgan and Asare, 2014). Mental health service is provided in these three psychiatric hospitals, regional hospitals, and some district hospitals. Four out of five private hospitals also have mental in-patient facilities (Roberts, Morgan and Asare, 2014).

The private-for-profit offer similar services in cities and towns. The biggest group of private health providers is the Christian Health Association of Ghana. At the community level, private operators are usually chemical shops, midwives, and Traditional Birth Attendants (TBAs). Traditional Birth Attendants are women who assist mothers to deliver usually at home. They may have learned their skills themselves or it was passed on from another TBA traditionally. Their training is largely traditionally based on skills transfer. Private non-profit healthcare providers are dominated by mission hospitals; both Christian and Muslim. There are also a few clinics run by NGOs.

Asante and Zwi (2009) discussed in their exploratory study on resource allocation in the health sector of Ghana, the geographical inequalities of health facilities and services. For example they provided that as the doctor ratio in the country is one doctor to about 17,929 people averagely, in the Northern part of the country, this could be about 75,000 people to a doctor.

2.2.2 Health Financing (National Health Insurance Scheme)

International Donor funding from agencies like the United States Agency for International Development (USAID), Danish Development Agency (DANIDA), Department for International Development (UKaid) and from UN groups like UNICEF plays a key role in health financing in Ghana (Asante and Zwi, 2009). Data available indicates that a substantial portion of Ghana's health financing is from international sources. Between 2005 and 2010, donor funds fell significantly from US\$360.48 million to US\$178.93 million. This indicates a decrease of 65%, from 52.97% to 18.55% of total financing (The Ministry of Health, 2015). Until 2003, donors gave funding directly to organisations and agencies, but under the decentralization and sector-wide approach (SWAp), these parallel funding arrangements have become more streamlined and managed by state agencies and commissions (Mayhew, 2003). SWAp is a pool where all development partners/donors put in their grants so that the Ghana Health Service will disburse them to agencies and organisations including NGOs for health service programme interventions. There are however donors who still ensure direct earmarked funding to regions, projects and civil society organisations. Mention made of USAID Donor funding implies donors' involvement in decision-making especially on which regions of the country and which projects their earmarked funding should go according to their priorities instead of responding to the strategic plan of the Ghana Health Service. This affects equity of funds distribution as their targeted regions and projects receive more funding than others (Asante and Zwi, 2009).

In 1985, user fees were introduced in the Health sector as part of the Structural Adjustment policy, and the user fees were a major constraint of the health system as it was in many African countries (Azevedo, 2017). It was popularly called cash-and-carry system (payment for health services at the point of access). It led to a decline in access to medical services. Before then, Ghanaians were paying a very minimal amount for health service as services were more free. The number of outpatient consultations per person per year (Per capita OPD attendance) consistently dropped at the introduction of the user fees (Seddoh and Akortey Akor, 2011). For this reason, the National Democratic Congress (NDC) led Government (government in power then) in 1997, to set up a task force to work on the introduction of a national health insurance scheme (NHIS) to replace the cash-and-carry system. The government was not successful. No public explanation was provided for the failure. However, it may have been related to leadership challenges, consensus and direction in the Ministry of Health and difficulties in implementation (Agyepong and Adjei, 2008). The New Patriotic Party came to power in 2001 and immediately set out to establish the NHIS. This was achieved in 2003. From 2004, citizens enrol in the NHIS and pay a premium of about \$10 yearly to participate. Meanwhile, free exemptions for ante-natal and childbirth delivery services were introduced earlier in 2003 (Asante and Zwi, 2009). In 2008, the government then rolled out a policy that exempted pregnant women

from paying premiums under the NHIS. This was a campaign promise by the NPP. Maternity services covered under the scheme included ante-natal care, delivery care, delivery, management of emergency obstetric conditions, and post-natal care.

2.2.3 Quality of Care

The improvement of “Quality of care” in the national healthcare systems, is embedded in a larger global movement toward Universal Health Coverage. The need for quality services is emphasized by Sustainable Development Goal (SDG) 3 which aims to ensure healthy lives and promote well-being for all. Target 3.8 of SDG 3 states that national systems should: “Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” (WHO-SDG, 2015). According to Odonkor *et al.* (2019) quality of health services implies that the services are patient/client focused. Patients expect a good staff attitude and professional approach to care (Lateef, 2011).

2.2.4 Health Reforms, Reproductive Health Policies, and Policies on Gender Equality

There have been various health reforms since the beginning of the government’s involvement in medical services in Ghana in 1925. The purposes of the reforms are to improve the quality, access, efficiency, and coverage of health services (Wahab and Aka, 2020). This section contains the review of key policies on reproductive health and those that relate to gender equality, focusing on the triggers for the reforms and the actors involved in the formulation of policies. The importance of the international dimension to Ghana’s reproductive health policies is a critical starting point because international agreements especially that of the UN and various regional bodies, have a direct bearing on policy formulation and reviews in Ghana.

Influence of International Treaties/Convention on National Policies

Ghana is a signatory to many international treaties and conventions. The country’s representatives attend UN conferences and participate in deliberations. It also participates in regional and bilateral dialogue on health and gender equality. Ghana, therefore, is a signatory to the treaties and conventions below and they have a great influence on national policies:

- The United Nations 2030 Agenda for Sustainable Development (<http://www.gh.undp.org/content/ghana/en/home/post-2015/sdg-overview.html>) - The agenda is packaged in 17 goals. Goal three is on good health and goal five is on gender equality.
- Millennium development goals set for 2015 - Goal 3 was to promote gender equality and empower women, goal 4 sought to reduce child mortality, Goal 5 aimed at improving maternal health, and

goal 6 was to combat HIV and AIDS, Malaria, and other diseases

(<http://www.gh.undp.org/content/ghana/en/home/post-2015/sdg-overview.html>).

- Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) (December 18, 1979) (UN Women, 2020)
- The UN Declaration on the Elimination of Violence against Women, (December 20, 1993), (FAO, 2012).
- African Charter on Human and Peoples' Rights (ACHPR) (FAO 2012)
- International Conference on Population and Development held in Cairo in 1994 (Republic of Ghana, 2014).
- Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (June 10, 2011) (United Nations General Assembly, 2020)
- Convention on the Rights of the Child (1989) (UNICEF, 2020)
- The 1951 Refugee Convention and the 1967 Protocol Relating to the Status of Refugees ((UNHCR, 2020).
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (March 1956).

National Reproductive Health and Gender Policies

Nationally, all policies emanate from the spirit of the constitution of Ghana, 1992. The constitution accords every citizen fundamental human rights, which include the right to health and the dignity of the person. This section is discussed under the main legislation on health and violence against women and national policies and strategies. The main legislations relevant to an examination of women's reproductive health and related gender-based violence and inequalities are the: Ghana Constitution, Health Financing/National Health Insurance Scheme (already discussed above), the Criminal Code of Ghana (1960) Abortion Law, Domestic Violence Act and Ghana AIDS Commission Act, National Population Policy, National Reproductive Health Service Policy and Standards, HIV and AIDS and STI Policy. The review of these various policy frameworks and initiatives provides insights into the main and multiple policy goals and concerns related to women's reproductive health, and the complexity of the health problems, policies, services, and systems.

Main Legislations on Health and Violence Against Women in Ghana

Title of Legislation	Overview of Legislation
<p>The Ghana Constitution</p>	<p>Article 33 of the 1992 constitution is dedicated to human rights.</p> <p>“(5) The rights, duties, declarations, and guarantees relating to the fundamental human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned which are considered to be inherent in a democracy and intended to secure the freedom and dignity of man (The Constitution of Ghana, Article 33 (5)).</p> <p>Also, chapter 6 of the constitution, which is on the directives principles of state policy sets out social, cultural, economic, and developmental rights including the right to good healthcare. The provisions of clauses (4), and (5) are referred to:</p> <p>(4) The State shall cultivate among all Ghanaians respect for fundamental human rights and freedoms and the dignity of the human person.</p> <p>(5) The State shall actively promote the integration of the peoples of Ghana and prohibit discrimination and prejudice on the grounds of place of origin, circumstances of birth, ethnic origin, gender or religion, creed, or other beliefs.</p> <p>Zuniga (2013) states that the Constitution review committee (2011) interprets the above provisions as recognition of the right to health as fully-fledged rights of the people of Ghana.</p>
<p>Abortion Law</p>	<p>Before 1985, abortion was not permitted under any circumstance under the Criminal Code of Ghana (1960, Act 29) on the grounds of the right to life of the unborn child. In 1985, however, the abortion law was liberalized to reduce the incidence of unsafe abortion. This liberalization was seen by many reproductive health practitioners and advocates as providing enough room for many women to be able to seek abortion services, but according to studies such as conducted by Rominski <i>et al.</i> (2014) on female autonomy and reported abortion seeking in Ghana, due to ignorance of the law, lack of money and stigma associated with abortion, women could still not access safe services. Jehu Appiah (2009) also contends that the liberalization of the law was not accompanied by provisions for services in the reproductive health policy and therefore women could not access the services due to lack of service availability. In 2006, as a</p>

	<p>result of engagements on safe abortion by NGOs with the Ghana Health Service, the service released new protocols for safe abortion services by expanding service points (Jehu Appiah, 2009).</p>
<p>Criminal Code of Ghana 1960 on Female Genital Mutilation and the Criminalization of Trokosi (Female Ritual Servitude).</p>	<p>Female Genital Mutilation (FGM) is widely practised in the three northern regions. However, because of migration, FGM is found in other regions of Ghana. Research conducted in 1998 indicated that the prevalence of FGM was estimated to affect 8-9% of all women in Ghana (Odoi-Agyarko, 2003). By 2011 prevalence had decreased to 3.8% due to education on its harmful effects and criminalization of the practice. According to Odoi -Agyarko (2003), the main reasons for people undergoing FGM are cultural and religious beliefs, parental pressure, and superstition. Others also practise it without knowing the reasons. Trokosi, a traditional ritual servitude of girls, practised in parts of the Volta region, was also a subject of much advocacy.</p>
<p>The Domestic Violence ACT, 2007</p>	<p>Through advocacy and campaign activities by a coalition of women groups, the Domestic Violence Bill became law in 2007 (Adomako Ampofo, 2008). This was a major event that gave expression to violence against women by giving the phenomenon a presence and a name. The Domestic Violence Act (2007) forbids threat or harm to a person: threats to commit or acts resulting in physical, emotional, and economic abuse, harassment including sexual and intimidating behaviour. It, therefore, provides the legal framework on which sexual, physical, and emotional abuses could be prosecuted under the law.</p>
<p>Ghana AIDS Commission ACT, 2016</p>	<p>The Ghana AIDS Commission ACT (ACT 938) was assented on December 30, 2016. The main aim of the Commission is to formulate policies and strategies on the HIV and AIDS Epidemic and direct and coordinate activities in response to HIV and AIDS, prevent and control HIV and provide for management of the HIV fund. Its history is from 2002, ACT 613 which established the Commission as a supra-ministerial and multi-sectoral Advisory Board to coordinate all the activities of relevant ministries, Civil Societies (CSOs), and the private sector. Major issues that ACT 938 covers are the rights, participation, and freedom of movement of Persons Living with HIV.</p> <p>Some of the key responsibilities of the Commission are mobilization and management of funds, advocacy, generating strategic linkages, providing leadership & promoting research, planning and co-ordinate activities concerning the national response,</p>

	<p>monitoring and evaluating the HIV and AIDS response, test facilities, and test kits, regulation of prevention services, regulation of anti-retroviral drugs and treatment services (The Ghana AIDS Commission 2020).</p> <p>Human rights issues of persons living with HIV are also covered by the ACT. The rights protected by the ACT include - non-discrimination, rights to health, rights to enjoy a standard of health services with dignity, and the right for no medical treatment or research on a PLHIV to be conducted without consent except where the person is unable to give consent according to the designated professional.</p> <p>Within this ACT, Persons living with HIV also have - rights to reproductive health, the family right, the right to safe sex, and the right to marry and have children; whereby HIV status does not constitute a valid reason to oppose the marriage. Other rights issues stipulated in the ACT are the right to privacy, and no disclosure of HIV status to a third party without consent, except a health care provider who needs the information to take care of the client for research where anonymity is assured.</p> <p>Any breach of the rights of persons living with HIV by any person if prosecuted attracts 18 months to 3 years of both fine and imprisonment.</p>
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Current Government Policies and Reproductive Health Strategies	
Title of Policy	Overview of Policy
HIV and AIDS and Sexually Transmitted Infections (STI) Policy	In 2004, the HIV and STI policy was formulated by the Ghana AIDS Commission with input from government agencies, the private sector, academia, and NGOs. It sought to provide the framework for service delivery and also stipulate human rights provisions concerning HIV and AIDS. The Policy was revised in 2013 to accommodate changes in the response due to changes in infection and disease patterns and developments in the response both in the national and international arenas, for example, the Millennium Development Goals (The Ghana AIDS Commission, 2013). The goal of the policy is to create a favourable environment for every aspect of HIV and AIDS, STIs prevention, care, and support. Under the policy, government and traditional leaders are called upon to ensure the elimination of customs and traditions that make women vulnerable to HIV

	and AIDS. It also promotes the use of Anti-Retroviral Therapy (ART) to reduce the risk of mother-to-child-transmission (Ghana AIDS Commission, 2013).
National Population Policy	Reproductive health service delivery in Ghana started with family planning services. Ghana's family planning programme emerged from population census programmes around the world between 1950 - to the early 1970s. Ghana's first population policy was thus formulated in 1969, as a response to international discourse on population growth (Caldwell and Sai 2007). The country became the third in Africa to do so (Kwakye and Cofie, 2015). The policy was formulated to curb population growth and high fertility rates. It was reviewed in 1994 to accommodate emerging demographic, health, and environmental issues, such as HIV and AIDS (Odoi-Agyarko, 2003). Selected reproductive health targets that the policy sought to achieve were to reduce the maternal mortality rate from 220 maternal deaths per 100,000 live births by 75 per cent by the year 2020 and the total fertility rate (births per woman during her reproductive age) from 5.5 per cent in 1995 to 3.0 per cent by 2020 (Government of Ghana, 1994). The policy also hoped to achieve a contraceptive prevalence rate of 15 per cent of reproductively active women by the year 2000, and 50 per cent by the year 2020; and reduce the population growth rate from about 3 per cent per annum to 1.5 per cent per annum by the year 2020 (NPC 1994 as cited in Ghana Statistical Service <i>et al.</i> 2015 pp4). The targets for contraception use were set to achieve the overall population targets and also to make it incrementally achievable as the structures and systems for implementing the population policies get more established (Adjei and Billingsley, 2017). The 1994 National Population policy also aimed at reducing the infant mortality rate from 66 infant deaths per 1,000 live births to 44 in 2005 and 22 in 2020 (National Population Council, 1994).
National Reproductive Health Service Policy and Standards	The Programme of Action of the International Conference on Population and Development (ICPD) adopted in 1994 created a shift from a focus on population and fertility reduction to addressing issues of sexual and reproductive health (Roseman and Reichenbach, 2010). The ICPD therefore influenced and resulted in important changes in Ghana's reproductive health policy from population-oriented policy to women's reproductive health needs. The policy standards were first published in 1996 by the National Health Service and reviewed in 2003. The third edition was published in 2014 to accommodate the current paradigm shift towards task sharing/task shifting, to offer universal access to quality reproductive health care. The concept of task sharing enables

<p>some aspects of Reproductive Health services to be provided by community-level health workers without compromising quality (Ghana Health Service, 2014).</p> <p>One of the key components of the policy is the discouragement of harmful practices and gender-based violence that affect the reproductive health of women. This would be achieved through the creation of awareness of the impact of violence on the reproductive health of women, providing appropriate healthcare to victims, and linking victims to institutions that help to address Gender- Based Violence (Ghana Health Service, 2014). The Department of Gender of the Ministry of Gender, Children and Social Protection, Non-Governmental Organisations (NGOs), National Population Council, Society of Gynaecologists and Obstetricians, development partners, Nurses, and Midwives Council, and the National Population Council supported the development of the policy.</p>
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All the above policies discussed have relevance for reproductive health services and women’s rights and provide a framework for the protection of rights of people including women. In addition to the review of policies, this section of the literature review has provided an overview of Ghana; its socio-economic context and reproductive health indicators. Focal issues for this thesis are the associations and relationships between the issues and trends discussed above and the social determinants of reproductive health. The next section reviews literature on violence against women in Ghana and its impact on women’s reproductive health. Feminist theories, providing theoretical context for discussing violence against women are also reviewed.

2.3 Feminist Theory, Gender Inequality and Violence Against Women

This thesis draws on the feminist theory of gender and gender inequality, and policy studies of the role of advocacy groups in the social policy process. In the first part of this section, I review feminist theories in broader contexts, especially those whose arguments have a direct bearing on violence against women. The second part reviews gender inequality as a key theoretical framework in examining violence and its effect on women’s reproductive health: body ownership, women and economics, and women and political representation, evidencing how these are intertwined in women’s experience of violence. The third part of this section defines violence against women and explores how violence against women exhibits itself in Ghana. It reviews studies on violence in an attempt to establish the magnitude and nature of the problem in Ghana and internationally. It also engages with the research literature to explore the effects of violence on women’s reproductive health. The section argues that not many studies have specifically focused on the

effect of violence on women's reproductive health and how women's advocacy groups have engaged the policy process in addressing the issues.

2.3.1 Feminist Theory and Gender Inequality

Feminist political theory is a range of political ideologies, concepts, and perspectives that examine and support women's equal legal, political and economic rights with men (Bryson, 2016). There are different kinds of feminism informed by history, ideology, and experiences; notable among them and relevant to this research are liberal feminism, socialist feminism, radical feminism, intersectionality, black feminism, and post-colonial feminism. These feminist perspectives express different needs and perceptions of women in different societies or situations.

Liberal feminism sees the relationship between the sexes as one of inequality, subordination, or oppression and recognises that this is a lack of formal rights and opportunities rather than a fact of nature (Bryson, 2016). Socialist and Marxist ideas of state ownership social class, inequality, and common ownership of wealth and production inform socialist feminism and the main argument is that inherently unequal economic class relations within capitalist economies are at the root of male dominance and that structures of gender, race, and class all contribute to constructing inequality (Gordon, 2013). Radical feminism is informed by women's experiences as moulded by culture and identity which defines the essential nature of womanhood and manhood, and it asserts that male power is groomed by patriarchy and moulds all relationships between the sexes: both public and private. Radical feminists contend that the threat and reality of violence sustain patriarchy. It is radical feminism in the 1960s and 1970s that brought to public discourse that domestic violence and rape, and not just patriarchy, as serious problems that governments must address. Though many women have worked towards gender equality, there are a group of women who do not want to term their collective activism 'feminism' or to be known as feminist. In the essay 'What's in a name? On writing the history of feminism', Moses (2012) posits that feminism means different things for women activists of different eras and with different areas of focus. Moses (2012) however makes a case for adopting feminism as a common identification for gender politics because of its strategic value.

One of the concepts of feminism that has gained theoretical grounds in the 21st century is intersectionality. Intersectionality postulates that conditions of social or political life are shaped by multiple factors of race, gender, and class and not merely by one of these factors (Collins and Bilge (2016). Many experiences of women of colour are not subsumed in the race or gender discourse but the intersectionality of sexism and race as categories produce experiences that cannot be captured wholly by looking at race or sexism

exclusively. Crenshaw (1991) further discusses intersectionality in three areas: structural, political, and representational. Intersectionality as an analytical tool became evident in the 1960s when African American feminists realised that the use of a single factor of race or gender or class left little space to address complex social problems (Collins and Bilge, 2016).

Crenshaw postulates that the violence women of colour experience is just the physical evidence of their subordination but underlying that, is the unemployment, underemployment, and poverty that make them subordinate in their relationship. She argues that providing solutions to violence will be effective only when an alternative to structural limitations (poverty) is available. The unemployment situation is influenced by the structural problem of racial employment discrimination. This observation was among women who sought shelter after being battered. Collins and Bilge (2016) argue that inequality in income or wealth does not fall equally on everyone, and that class, gender, citizenship, and age make some people more vulnerable than others.

The argument of black feminism does not suggest that 'Black' women or even African women or women in the 'Third World' are generic with identical interests and desires. Their lives are fluid and change over time (Stein, 1997). For instance, the issues that shape the discourse of intersectionality may not exhibit themselves among black women in their 'home countries in the same way as it exhibits themselves among black women in the diaspora. For these reasons, feminists in different parts of Africa seem to focus on different inequality issues and these issues are shaped by women's political, cultural, and economic circumstances (Adomako Ampofo, Beuku-Bett and Osirim, 2008).

In recent times, African feminists have raised issues on the need to consider other parameters that shape the lives of many women for instance 'race' and 'ethnicity' and the effects of colonialism and post-colonialism. The argument lies in the notion that though colonialism has ended, its legacy still influences the world order (Bryson, 2016). Mikell (1995) agrees with other African feminists those African women suffer multiple sources of oppression. Economic and cultural imperialism produce exploitation in the third world. Non-western nations provide a source of cheap labour for western nations. The Structural Adjustment Programme of the Breton Wood institutions has produced poverty in developing countries.

African feminists like Oyewomi (1997) assert that colonialism brought changes in African society including changes in gender relations and roles. Oyewomi illustrated that before colonialism women held leadership positions in their communities. There were female chiefs. But the process of colonialism put state leadership

in the hands of males and excluded females; “the transformation of state power to male-gender power was accomplished at one level by the exclusion of women from state structures (Oyewomi, 1997, p. 125). Similarly, the removal of adjudication from leaders of lineages into judicial structures in which only males were judges also excluded females from their hitherto adjudication roles, to the extent that issues of marriage, pregnancies, and divorce were all sent to courts structured to be led by males. Hence the inequality experienced by African women is also shaped by the effects of colonialism namely the importation of the gendered society of the Victorian era in Britain to certain parts of Africa.

In West Africa, according to Adomako Ampofo (2008), the fragile economy and detrimental effects of neo-liberal economic reforms as well as women’s poor representation in government remain significant features of gender inequalities. This is because the impact of the socio-economic and cultural processes involved in colonialism and post-colonial development has always been highly gendered as discussed above and has induced sexual violence and the control of reproduction (Bryson 2016). Women continue to resist such policies in organizing against multinational corporations and the state.

2.3.2 Gender Inequality

Gender inequality is a major driver of violence against women and its adverse effects on women’s reproductive health. According to Cusack’s (2009, p.7) “Gender refers to the socially and culturally constructed of what it means to be a woman and a man as well as the relation established between a woman and a man”, not simply biologically given. This is demonstrated by how much diversity across cultures and periods there is in these constructs. The constructs as stated earlier, are of various levels and areas of politics and relationships: the state, religion, the community (culture/ethnicity), and domestic levels. Violence exists on institutional and structural levels as well as on individual and domestic levels (Fulu and Miedema, 2015). The discussion of gender and violence against women will focus on feminists' stands in three main conceptual areas: women and body ownership, women and economics, and women and political representation. This thesis claims that these conceptual areas are interconnected, and they induce violence against women which in turn affects the quality of women’s reproductive health.

Women and body ownership

According to Lonergan (2012), women must have the political, economic, and social power to make healthy decisions about their bodies and sexual reproductive health. However, this is often not the case and the right to body ownership does not lie in the hands of women, either in marriage or non-marital heterosexual relationships. Women’s control of their sexuality, and issues of choice on reproduction, among others, are

limited by socio-cultural expectations. Women in Ghana often do not determine when, where, and how to have sex. This is indicated by Akumatey and Darkwa (2009) in research they conducted on violence and women's vulnerability to HIV in Ghana. The women in this study reported that women often feel they are passive participants in sexual acts. They are therefore not able to negotiate for safer sex. This vulnerability, set against the concept of masculinity in Ghana which strongly supports notions of men's entitlements to women's bodies, perpetuates men's control over women's reproductive health decisions, for example, how many children to have, when to have them, and pressure on which sex the child should be. In such cases, women may give birth to many children just to please their husbands and to maintain their marriages which may be their only means of economic survival. This can lead to fistula⁶ and death in women.

Women's lack of control over their bodies and its effect is evident in the statistics on gender and HIV in Ghana. Women form the majority (66%) of HIV and AIDS cases in Ghana at present (Ghana AIDS Commission, 2022) Women are extremely vulnerable to HIV/AIDS and other STI infections, because of limitations on the control of their sexuality within and outside marriage, and due to exposure to extensive sexual networking via male partners' polygamous relationships (Baden *et al.*, 1994). When women refuse sex, they may be beaten or subjected to emotional abuse, sometimes through open extramarital relationships. Whilst the effects of emotional instability can lead to illnesses and hence difficult pregnancy, extramarital sexual affairs can also lead to sexually transmitted infections which can also threaten the lives of both mother and child.

Feminists argue that marriage is a gendered and patriarchal institution (van Acker, 2015; Offei Aboagye, 2004). The cultural definitions of womanhood or 'wifhood' provide a weak political standpoint for women. Many cultures in Ghana imply that wives are seen as subordinate to their husbands and hence must submit to them. This culture perpetuates women being treated as subservient in their relationships. It is perceived that the payment of the dowry (money/items requested by the bride's family to signify marriage) entitles the men to possess women and treat them the way they like, and this impacts negatively on women's reproductive health (Kaye et al 2005).

⁶ An obstetric fistula occurs when a woman has a prolonged, obstructed labour. She often labours in excruciating pain. During her labour, her contractions push the baby's head against her pelvis. Soft tissues caught between the baby's head and her pelvic bone compress, restricting the normal flow of blood. This cause sections of tissue to die, leaving holes - known as "fistulae", between the mother's vagina and her bladder or rectum. These holes cause incontinence and if she does not get treated, the woman will uncontrollably leak urine, stool, or sometimes both, for the rest of her life.

Extracted from the Fistula Foundation's website- <https://fistulafoundation.org/what-is-fistula/>

In qualitative research on kinship and intimate violence among 30 women in two districts in Ghana, a participant informed the researchers that:

He (my husband) tells me he is the head of the family, and he was the one who married me not the other way, therefore I have no right to tell him I am not ready for sex with him (Sedziafia *et al.* 2016, p. 14).

The marriage institution, therefore, becomes a ground for violence against women; sexual, battering, and psychological. Various systems of customary laws in Ghana which many marriages are contracted uphold men's supremacy over women. The interpretation of the legal provision of force in marriage in the Criminal Code of Ghana 1960 (ACT 29) until the advocacy of the Domestic Violence Act, did not favour women. The ACT states that:

...Save that the consent given by husband or wife at marriage, for marriage, cannot be revoked until the parties are divorced or separated by a judgment or decree of a competent Court (Criminal Code of Ghana 1960 Act 29 section 42 (g)).

The quote above means that the marriage institution is an implication that spouses have given up the right to withhold sex from the husband (Cantalupo, 2006). This provision was borrowed from British jurisprudence as a colonial legacy until it was repealed after the Domestic Violence Bill became law, it was interpreted to mean that a husband had unqualified access to his wife any time and anyhow. The clause on marital rape, therefore, became a bone of contention during the advocacy of the Domestic Violence Bill. Adomako Ampofo *et al* (2008) therefore noted that there is a lack of political will on the part of political leaders to promote changes in marriage laws that have adverse effects on women.

Women and Economics

The economy of the state and subsequently the economy of the family and individuals influence violence against women, and they affect women's reproductive health. Feminists argue that the neo-liberal economy fuelled by globalization enforces poverty in developing states (Bakker, 1994). Neo-liberal economics emphasizes the free operation of the market for economic growth and hence the role of states in providing public services diminishes. The introduction of the Structural Adjustment Programme (SAP) by the World Bank and western donors in the 1980s as the main development paradigm, became the vehicle through which neoliberal policies were implemented in many countries and for that matter Ghana. Nations had to fulfill the conditions of The Structural Adjustment Programme before they could access financial assistance from the World Bank. The conditions were trade liberalization, withdrawal of subsidies, and reduction of

the role of the State in the production of public services (Oppong, Opong and Odotei, 2006). Bakker (1994) asserts that under SAP, governments lost the ability to regulate national economies because production became international and globalized. This research argues that neoliberal economics impact violence against women in two main ways: the effects of the macroeconomic environment that induces poverty directly on women; and the poverty of male partners which creates conditions that trigger violence from them. Although Kraus (2006), regarding GDP rates, argues that the Structural Adjustment Programme (SAP) engineered growth and economic recovery in countries, there is also significant evidence that the Structural Adjustment programmes contributed to rising rates of poverty. The SAP period was characterized by high rates of unemployment, an increase in unstable forms of work in the informal sector dominated by women, hiked prices, and a decline in food security (Apusigah, Tsikata and Mukhopadyay, 2011; Lingam 2005). As Lingam postulates, the informal sector is characterized by low-paid, labour-intensive jobs with high occupational risk. Women had to work long hours to earn a little more to make up for men's loss of jobs because one of the key requirements of the SAP was job cuts and freezing of employment by government. Many men therefore lost their jobs to retrenchment. These economic problems and inequalities are directly linked to rates of domestic violence emerging from the effects of neoliberal policies (Yeboah and Batse, 2009). Further economic conditions can increase risks to health - for example, hard labour could induce abortion in some women. Increased hours of work for women does not reduce or change their domestic roles as producers of human resource and day caregivers as well as providing care for sick family members. All the hours put in these roles to support the economy are not quantified and paid for. Bakker (1994) asserts that the undercounting and under-evaluation of women's work is fundamental to the economic subordination of women. The increased workload of women becomes an incentive for more children to help bear the burden of work.

Lingam, in his study on structural adjustment in 'Third World' countries, sums up the issue of women and labour in his words below which apply to the Ghanaian context:

The social construction of women's subordinate position is used by capital to divide and segment the labour force and treat women as inferior workers in the marketplace. Women's unequal position in the household mediates their participation in markets and substantially limits their capacity to respond to market opportunities (Lingam, 2005, p. 9).

The withdrawal of public services and cuts in social expenditure during the SAP period as demands of the programme, led to the introduction of health user fees as means of reducing the government's spending on health referred to as the cash-and-carry system. This made it difficult for the poor in Ghana, the majority being women, to access health care (Owoo and Lambon-Quayefio, 2013) which included pre-natal, ante-

natal, and post-natal care. Access to healthcare declined in the 1980s when user fees were introduced and when government expenditure on health dropped (Owoo and Lambon-Quayefio, 2013).

Bakker (1994) observes that the persistence of women's subordination may preclude them from being able to implement restrictions on the size of their families and hence the unmet need for family planning is high irrespective of the availability of contraceptives. Sexually active women or married women who want to postpone childbirth for two years or more or who want to stop giving birth but are not using any contraceptive are said to have an unmet need for family planning. The Ghana Statistical Service (2015) reported that Ghana's unmet need for family planning in 2014 stood at 30% for married women and 42% for unmarried but sexually active women, showing a slight decline of 7% since 1993. When services are available at clinics but there is no money to access them and hence the reproductive health of women remains poor. Cuts in social spending have also been associated with an increased maternal mortality ratio. For example, a study in Nigeria shows that maternal deaths in Nigeria during the 1980s doubled in the Zaria region along with a decline in institutional delivery during the implementation of SAP in the country (Lingam 2005).

It is argued by Lingam (2005) that the transfer of public to private ownership, the reduction of social spending, and protective mechanisms such as subsidies led to the 'commodification' of sex and sexuality. This puts women at risk of sexual abuse and prostitution. Adolescent girls are exposed to single or multiple long-term or short-term partners who do not use condoms because they need money. The rise in prostitution and transactional sex led to sexually transmitted infections including HIV and AIDS and other reproductive tract infections. The HIV sentinel Survey for 2018 indicated that infection among commercial sex workers was 7% whilst prevalence among the general population was 1.69% (HIV Sentinel Survey 2018).

The bride price offered for marriage becomes a capital source for poor families. The marriage of female children is regarded as an opportunity for families to raise capital and also have a continual source of financial assistance. Poor families, therefore, ask for huge bride prices and give their girls off in marriages. Girls and young women are sometimes given to older men who are already over-exposed sexually and this can be a platform for violence where young women are sexually abused and exposed to STIs including HIV. Girls given to marriages before the legal age of 18 also get pregnant when their bodies are not mature to carry the pregnancy. The Ghanaian Times reported an increase in the incidence of fistula among child-mothers (The Ghanaian Times, 2016). The essence of the issue was captured by Stein (1997, p.129)

as...“Unless and until women are powerful enough to negotiate their sexual relationship independent of economic benefit, they are at risk of sexual abuse.

Men’s perception and stress from poverty; provision of food, clothing, shelter, and his orientation to use violence and abuse to manage these stresses and inadequacies result in violence against women. Violence can generate from stress resulting from women’s need to rely on men economically. Women in poor homes are more likely to experience violence. Britwum and Cusack (2009) indicate that economic issues play a major role in fuelling misunderstandings that trigger violence. Data from the national research on violence against women indicate that economic issues ranked equally high on determinants of violence. Husbands’ spending habits ranked first, preventing pregnancy ranked second and responsibility for children's upkeep ranked third (Cusack no date). Britwum and Cusack (2009) state that the cultural role of men as providers combined with poverty can trigger men’s behaviour and abusive actions against women.

Britwum and Cusack (2009) argue that men can choose or reject violent behaviour irrespective of their economic conditions. Since the same poor conditions do not drive women to violence, it indicates that other factors account for it and these include the socialization of men - how the cultural context and norms prize male sexual conquest, sexual violence, aggression, and control.

Property Ownership and Inheritance

Apart from the economic conditions nurtured by SAP which trigger stress in men and subsequently produce violence against women, there are other cultural limitations such as property ownership and inheritance (land), which also leave women economically weak and hence expose them to violence. Culturally, women have limited rights to their husbands’ property, where husbands die intestate. The PNDC Law 111 introduced in 1985 on Intestate Succession gives wives and children the right to inherit the property of a deceased husband and father. It provides a framework to define property rights for surviving nuclear families (Baden, 1994). However, it was found by Baden (1994) that loopholes still exist, and the application and enforcement of the law are fairly limited. Moreover, many women, because of lack of education and information, may not even be aware of this provision to claim it. Further Baden found that women, even when they are aware, lack of money to access legal support discourages many from pursuing their rights.

In many customary settings, inheritance is passed on to male children (Bowman and Kuenyehia 2003). Family properties are handed over to male children. Even in matrilineal systems, inheritance is handed over to nephews. This implies that women usually have no claim to the land, an important capital for wealth

creation. Lack of landed property also prevents women from seeking credit facilities to expand their trading activities. Studies have found that since women do not have landed properties, they are usually not able to access credit facilities with the ease that men do (Chuku, 2002). Lack of money implies limited access to health care and hence reproductive health services. It also implies dependence on men as providers which can form the basis of unequal relationships which is intimately connected to the prevalence of physical and emotional abuse.

Feminists believe that women's access to the realm where decisions on the economy are made and resources are allocated, is important in ensuring that women's needs are mainstreamed in both policy formulation and implementation (Mikell, 1995).

Women and Political representation

Adomako Ampofo, Beuku-Bett and Osirim (2008) state that over the past two decades, African women have made major strides in political office holding and in advancing gender equality, human rights, and democratization in African states. Though earlier feminist studies have recognized the significant increase in the number of women in political positions as a result of quota systems, Chuku (2002) asserts that in the 21st century, African women in parliament, cabinet positions, and various political offices are still few, and she calls this tokenism because the number in the political office does not represent their dominance percentage in the population of their countries. The 1995 United Nations report showed that out of the 51 countries in Africa twenty-six were below the global average and 25 were above it. The percentage ranged from 0.0 per cent in countries like Benin, Djibouti and 3.3 per cent in the Seychelles, while Nigeria fell to 6.8 per cent (Tinker, 2004).

Although the Constitution of Ghana guarantees all persons equal opportunity to participate in decision-making at every level, women are still not able to participate equally in the public decision-making realm because of socio-cultural structures and traditional practices including the burden of motherhood and care. Food and Agricultural Organisation of the United Nations (FAO), 2012). In 2008, only four ministers out of 30 were women and out of 49 deputy ministers, only 14 were women - severely limiting the potential number of women cabinet members.

Parliament is the legislative wing of government, elected by their constituency into the office to make laws. Since 2016 there have been 20 women out of the 230 elected parliamentarians in the Government of Ghana. With few women in the legislature, it is possible that Bills on gender issues will not get the necessary support

to be passed into law, or even when passed, there can be pressure to remove critical clauses that men think would not inure to their favour. Adomako Ampofo (2008) asserts that the Domestic Violence Bill received such opposition in parliament and the rejection of the clause on marital rape before the passing of the bill into law. It is also in the cabinet that budgets are discussed and approved. Since women are few in these realms, it has been prevalent that the interest of women which concerns funds for reproductive health, for instance, will not receive much push.

The majority of the Judiciary are men. This is crucial because it is the judiciary that interprets the law and also ensures justice. If the realm is dominated by men, who are conditioned by the socio-cultural practices of their cultures, they are likely to view women's complaints/cases of sexual violence and other forms of violence from the cultural point of view and hence may fail to uphold women's rights (Dawuni, 2016).

One of the key arguments on representation is whether the representation of numbers implies the representation of voice. It is argued by Tinker (2004) that though female ministers may not necessarily represent women's interests, their presence has the potential to impart sounds to voices that often go unheard and this will also enhance political and social equality. Feminists discuss women's political representation, not only about occupying political positions but also women organizing for political change in their countries through movement/coalition building for advocacy activities (Viterna and Fallon, 2008). These activities affect the policy formulation and implementation processes and thereby can help improve the lives of women. There are however arguments about whether women's representation in the political realm implies their fighting for women's rights and also whether men can be good women's advocates.

2.3.3 Violence against Women

Violence against women is one of the key determinants of the quality of women's reproductive health. Violence against women is a global phenomenon, but until the late 1990s and early 2000s, it had received relatively little public attention in Ghana (Amoakohene, 2004). In Ghana, the practice is widespread at institutional, community, and domestic levels, taking a variety of forms. Two major events brought the menace to the national public discussion: the national level research conducted by the Gender Studies and Human Rights Documentation in 1999 (Cusack, 2009); and the activism of the Domestic Violence Coalition towards the passing of the Domestic Violence Act (2007) (ACT 732) by parliament (Adomako Ampofo, 2008). More critical also is that few studies have specifically been conducted into the effects of violence against women on women's reproductive health. Prior to the two events mentioned above, had been the serial killing of women whom CCN.com

(<http://edition.cnn.com/2000/WORLD/africa/12/19/ghana.murders.reut/>) reported to reach 30 by the year 2000 without a strong commitment by government to find the killers.

Cusack (2009) argues that defining violence against women is a challenging task. One may be too specific which will exclude many women's experiences or may be too general to overlook some experiences. Price (2005) asserts that the definition of violence should be limited to physical abuse only. Mackinnon (1998) however argues that violence should include the threat of the act and violation of the mind. Research conducted by Del Rio and del Valle (2017) in Spain established a high level of psychological violence; controlling behaviour, and emotional abuse. Out of the 10,171 women who participated in the study, 25% reported experiencing controlling behaviour whilst 21.9% experienced emotional abuse.

The WHO defines violence against women as:

Any act of gender-based violence that results or is likely to result in physical, sexual or psychological harm or suffering to women including threat of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life" (Statistical Service, 2013, pp28; World Health Organization, 2016).

This definition is useful to this research because it encapsulates all forms of violence allowing for discussion and drawing of literature on all forms of violence. It is also the United Nation's definition of violence against women and hence it is widely recognised and used across countries, agencies and polities. It is also the working definition adopted by the Ghana Health Service.

The Domestic Violence Act of Ghana (2007) expands the elements in the UN definition and includes multiple forms of violence: sexual assault, controlling and coercive behaviours, force and the threat of force, deprivation of financial resources, intentional humiliation and forcible confinement, conscious infections of sexually transmitted diseases such as HIV. In this research, intimate partner violence and violence against women will be used interchangeably as seen in many literatures (Cusack, 2009; Tenkorang *et al.*, 2013). The Domestic Violence ACT, 2007 exposes these types of violence in the domestic settings which previously may be considered private to public discourse.

Kishor and Johnson (2004) state that about 50% of women worldwide have experienced a type of violence. More recent data provided by the World Health Organization (WHO) reliably estimates around 35% of women have experienced violence either physical or sexual (www.who.int/mediacentre/factsheets/fs239/en/, García Moreno *et al.*, 2013). This shows a reduction in statistics, but 35% prevalence still calls for attention. Cusack and Manuh (2009), examining violence against

women in Ghana, assert that it is associated with persistent forms of gender inequality; poor livelihoods, lower economic productivity, higher risks of STIs including HIV and serious and poor physical and mental health.

Adomako Ampofo (2008, p. 405) reports that data compiled from the report of cases by victims at the Domestic and Victim Support Unit of the Ghana Police Service between 1999 and 2003 indicate that annual reported cases of defilement (having sex with a girl below the age of 16) increased from 154 to 509 and annual cases of the incident of threatening behaviour from 21 to 461. Spousal abuse or intimate partner violence is one of the most common forms of violence against women in Ghana. The Gender Studies and Human Rights Documentation Centre conducted research in 1999 on violence against women and children in Ghana. The national level research, involving a sample of 1588 women and 481 girls selected from all ten regions of Ghana, revealed that 32.8 per cent of this large sample of women experienced physical violence. Further, 25.6 per cent experienced psychological violence and 20.5 per cent experienced sexual violence (Yeboah and Batse 2009). The 2008 Ghana Demographic and Health Survey also indicates domestic violence prevalence of between 33%-37%. This data is similar to the results of Owusu Adjah and Agbemafle's research involving 1524 of ever-married women in 2016. In their research, 33.6% of women ever experienced domestic violence (Owusu Adjah and Agbemafle, 2016, p. 3). The data spanning from 1999 to 2016 provided above shows that there has not been a decrease in the prevalence of domestic violence and that the statistics still hover around 32%-33.6% within a 21 year period.

The specific acts of violence against women in Ghana that affect women's reproductive health include child prostitution, rape, partner battering, and trafficking of girls for the sex trade. Child marriage, widowhood rites, female genital mutilation and Trokosi (a practice in which young girls are forced into slavery to atone for offences committed by family members), and also all other traditional practices which perpetuate violence against women (Ghana Statistical Service 2013, King, 2006). Cusack (2009) adds to the list of violence in Ghana: acid thrown on women's bodies, burning of body parts and cutting off limbs, stalking and harassment, and accusations of witchcraft accompanied by severe beatings and sexual slavery. Owusu Adjah and Agbemafle (2016) argue that physical violence includes deprivation of personal access to food, water, clothing, shelter, rest, or subjecting a person to inhuman treatment. All forms of physical violence can induce psychological violence also. Violence could also be purely psychological or emotional: controlling and coercive behaviours (Chirwa, *et al.*, 2018), threats of withdrawal of affection, threats of divorce, constant verbal abuse of a spouse, and open sexual relationship with another. These acts make a person feel constantly unhappy, miserable, humiliated, afraid, jittery, and worthless (Owusu Adjah and

Agbemafle, 2016). Violence can also be economical, for instance, deprivation of rights to economic facilities or income of the family and hindering the use of property in which a person has a material interest or right by law. Women sometimes experience economic violence when their labour efforts are not paid for or when they are evicted from their marital homes without any compensation, though they may have contributed years to the purse of the home (Akumatey and Darkwa, 2009).

Cusack (2009) contends that violence against women is rooted in Ghana's modern social order which emerged out of historical events (colonialism, neo-colonialism, nation building during independence), institutions (the state, culture, religion), and forms of social organisation. Adducing from Cusack's claims, there are explicit causes of violence against women identified. These include patriarchy, low level of education of women, the experience of violence in the past which makes it re-occur and drinking of alcohol by male spouses (Tenkorang, *et al.* 2013). When men are under the influence of alcohol, they lose their judgment and tend to abuse their wives. Owusu Adjah and Agbemafle (2016) group the causes of violence into two: personal and societal levels. On a personal level, they list young age, heavy drinking, low education level, low income, history of parental abuse, relationship factors, economic stress, poverty, and male dominance. They list the societal factors as traditional gender norms, societal norms, and political systems. The results of their research show that about 40% of the women who experienced violence were in the lower wealth quintile, also women with higher education were 45%-55% less likely to experience violence, and men with higher education were also less likely to be violent. Women with husbands who abuse alcohol were also 2.5 times more prone to violence. Previous experience with violence was also a predisposing factor. Research done by Chirwa *et al.* (2018) in Ghana corroborates the results of Owusu Adjah and Agbemafle. Substance abuse, educational levels, and unemployment by a spouse were found to be determinants of violence.

Though statistics show few men experience violence from their female partners, men have been identified as the main perpetrators of violence (Cusack, 2009). Patriarchy, as a feminist term, postulates that society is dominated by the male and hence all systems and structures support male dominance over females. Extracting this to marriage, women are expected to be submissive, and dutiful and not question the actions of their husbands. According to Tenkorang *et al.* (2013), patriarchy produces power imbalances in marriage rooted in the cultures of Ghana. This makes room for the acceptance of wife-beating and other forms of violence. The societal causes of gender-based violence are discussed in detail in the section on feminist theories and gender inequality below.

Though there have been efforts to bring to the fore violence against women in Ghana and its effects on women's political and social life, few of such works focus on the effects of violence on women's reproductive health. Studies conducted in Ghana by Pool et al. (2014) demonstrated that violence against women can lead to loss of pregnancy, loss of life of the pregnant woman, and neonatal mortality. The Ghana Family Life and Health Survey (GFLHS) 2015 reported that 30 out of the 192 women who reported having been physically assaulted were hit while pregnant (15.6 per cent), resulting in a miscarriage rate of 10 per cent (three women) and neurological complications to the foetus in 6.7 per cent (two women) of the cases. Violence against women impacts negatively on their physical and emotional health, their sexual health, and their freedom to choose their partners. Unwanted pregnancies, STIs, harm to sexual functioning, induced abortions, gynaecological problems, harm to foetuses, and hence stillbirth or defective births are also some of the reported and surveyed effects of violence on women's reproductive health (Cusack and Manuh, 2009). Women who experience violence have reported they are not able to access prenatal, ante-natal, and post-natal health services (Spitz and Marks 2002). They are also unable to control or negotiate for safer sex because of fear and cultural limitations which takes negotiation of sex outside the domain of women. Akumatey and Darkwa (2009) conducted qualitative research on gender norms, domestic violence, and women's vulnerability to HIV/AIDS in eight regions in Ghana with a sample size of 389 women infected with HIV. This large-scale study found that women are forced to have sex against their will. For example, many respondents reported negative experiences such as the respondent below who stated:

Maybe, then he wouldn't use anything at all, or you feel that lately your husband has been moving around a lot and you might want him to use something, but he wouldn't do it. He will use force to have sex with you. He wouldn't use the condom, and he will be forcing you. When that happens, you become very worried (Akumatey and Darkwa 2009 p.38).

There is a large international feminist literature that argues and evidence how the 'causes' of these problems are embedded in socio-economic-political structures that support dominant male behaviour towards women and provide limited legal and social protections and safeguards to reduce risks to women and girls and protect their human rights (Fullilove et al 1990: Cusack 2009: Mikell 1995). The next section provides an overview of relevant feminist theory.

The section above examined reviewed feminists theories and the under-researched aspects of violence against women and women's reproductive health. The prevalence, causes, and types of violence have been discussed above. The next section will review the literature on social policy formulation and implementation, narrowing on health policy as a policy field, advocacy, and advocacy groups in Ghana. This is the central point of the study. The section examines social policy as the realm where women's rights

advocacy groups work towards influencing policy formulation and implementation in Ghana as they relate to violence against women and women's reproductive health. Agenda setting is presented as the main theoretical framework to discuss advocacy by women's rights advocacy groups.

CHAPTER 3: SOCIAL POLICY, HEALTH POLICY, AGENDA-SETTING, AND ADVOCACY IN GHANA

3.0 Introduction

This chapter situates advocacy in the social policy-making discourse and hence critically reviews the literature on key concepts and theories of social policy-making, narrowing on health policy as a policy field, the Advocacy Coalition Framework (ACF) and agenda-setting as the main theoretical framework. It also critically reviews the conceptual and empirical literature about women's rights advocacy and provides an overview of advocacy groups in Ghana. More importantly, the chapter will review the literature on the influence of advocacy groups in the policy-making process, paying attention to (a) processes and roles in agenda-setting/problem and issue framing; (b) coalition/movement-building, and the dynamics within coalitions and between the coalition and policy actors, and (c) strategies/tactics used in achieving advocacy outcomes.

3.1 Social Policy and Health Policy as Policy Fields

Lewis *et al.* (2000) define social policy as a cluster of government policies to promote social ends. The promotion of social ends connotes the welfare functions of the state. Hogett (2000), however, asserts that social policy may not be about welfare alone, but well-being which implies the totality of the individual's social relationships. The main objectives of social policies, therefore, are to improve the well-being or welfare of citizens. The government has a responsibility to all its citizens and is expected to fund key social sectors such as education, health, and housing and provide support to the vulnerable. Dean (2018) postulates that social policy goes beyond the funding of social goods. It must transition into individuals having the freedom to choose their lives and to lead the kind of lives they value.

Social policy has a multiplicity of policy objectives - poverty reduction, social protection, fighting social exclusion, and promoting human rights (Dean, 2018). However, Dye (2010) asserts that social policy also includes the non-actions of government.

Dean (2019) also recognizes social policy is about social regulation and social control and can have a detrimental impact on welfare and well-being. Analyzing public policy, therefore, raises questions such as what the government and all state agencies have done, why they have done it, and the outcomes, what are the ends and means of social policy? In whose interests are social policies pursued? What are the

distributional and welfare impacts and outcomes of social policies? Social policy also regulates and orders society. It can limit the role of government, emphasising personal and family responsibilities; it can seek to regulate behaviour and be used for social control (Dean, 2019).

Dean (2019) states that sound health is widely regarded as a fundamental requirement both for economic productivity and for any kind of individual quality of life. The WHO (2022) defines health as:

a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

Craig (2014) argues that health is a social good. It benefits the larger number of people in a society and when everyone has access to health, it reduces inequality. Jones (1994) argues health is a social good because high levels of poor health, preventable disease, and health inequalities compromise societal and economic well-being and development and infringe on human rights. Culbertson (1999) in his study on trauma care said that healthcare requires a community-based and a system-wide solution beyond individuals and institutions because its needed resources cannot be provided by an individual or an organisation. According to Walt (1994 p.41) “health policy embraces courses of action that affect sets of institutions, organisations, services and funding arrangements of the health care system”. It includes actions or intended actions by public, private, or voluntary organisations that have an impact on health. Hill and Irving (2020) however state that Government has the responsibility to provide adequate health and social needs for its people. McDougall (2016), when examining global reproductive health policy-making, states that the reproductive health policy subsystems are composed of thousands of both state and non-state actors, governments, NGOs, UN Agencies, private businesses, health professionals, academics, and media. Though his study was on global policy on reproductive health, it applies to the national level reproductive health advocacy situation where many actors participate in the policy-making process. To tackle health inequalities, Kulaç and Özgür (2017) assert that the policies on reproductive health should be enacted from the reproductive health justice point of view, and clear about the goals and values that it is meant to enact, including social justice, well-being, and self-determination. It should embed critical reflexivity in questioning the role(s) of dominant groups and the effect of their behaviours and beliefs on policies.

3.2 Theories of Policy-making

Different public policy analysis models are used in examining public policy-making and implementation processes. The public policy process consists of many stages, actors, decisions, and actions (Hill, 2014, p.

7). There are complex sets of socio-political activities that constitute policy-making (Howlett, McConnell and Perl, 2017). According to the rational-comprehensive model, in the policy process, problems are conceptualized and brought to the government agenda, alternatives are considered, and selected solutions are formulated by public institutions and numerous actors. Policy proposals are viewed as applied, evaluated, and revised (Sabatier, 2007). The stages model propounded by Laswell (1956) presented the policy-making processes as having a progressive cycle of sequence. These stages in sequence are agenda-setting, formulation, legitimation, and implementation. Eger III and Marlowe (2006) added evaluation to the stages model while Brewer and deLeon (1983) also added feedback. Critical perspectives challenge this view and agree with Kingdon that the policy-making process is more chaotic. Mukuru *et al.* (2021), in their study on Interests and Power Underlying Maternal Health Policies in Uganda, affirm this.

In response to the failure of the stage models to capture the full range of ways that policy is developed, several theoretical perspectives emerged. Lindblom and Woodhouse in 1993 viewed policy as a more incremental, iterative process in which current social policies in part reflect historical and prior developments and legislation, and where policies are shaped and reshaped by multiple influences and contexts (Howlett and Migone, 2011). The incremental approach to policy-making suggests policy change and innovation are mainly achieved in incremental stages over long periods. Institutions, collectives, and individuals play a critical role in these changes. Compared to the top-down rational comprehensive model, incrementalism examines the role of embedded structures, cultures, and legislation, within policy-making processes and the multiple interests, and values of all people and groups involved. The strength of this theory is that it establishes public and social policy as multi-dimensional, multi-organisational, examines the dynamic between prior institutions and cultures, and attempts to reform these in new ways. It highlights issues of power and dependence within the policy action continuum: the emphasis is placed on issues of interests, motivations, and behaviours. However, the incremental approach is criticized for presenting the policy-making process in pieces instead of proposing a strategy to achieve policy goals and that the step-by-step approach risks missing the overall policy goals.

The theoretical perspectives discussed above, each focus on a particular factor that influences the policy process: policy actors (institutions, networks, individuals), actions, and ideas. The section below will evaluate these elements and demonstrate that policy-making encompasses all these elements. According to Kingdon (2012), institutionalism highlights the importance of political institutions in policy development. Institutions include laws, procedures, constitutions, organisations, and rules that are central to the political system. These structures and institutional actors include parliament, government, bureaucratic agencies,

political parties, pressure groups, think tanks, and the media (Kulaç and Özgür, 2017). Thus, the new institutionalism does not cover only the constitution and formal political practices and actors but also less formal organisational networks (Rhodes, 1999). Hill (2014) asserts that: politicians, civil servants, publicly employed professionals, and pressure groups are involved in the policy-making and sometimes, there are even other less directly involved but influential actors who may not think they are. The rules of policy development show that the structures of the political institutions shape the kind of policies to be developed (John 2003). In other words, the institutions are only one part of the process and individual action, or the collective action of individuals is also central to the policy process.

More modern theories of policy-making argue that unitary systems of government have largely been accompanied by more fluid networks, partnerships, and quasi-governmental bodies. Ball (2012) argues that significant changes are taking place in how policy gets done globally. The involvement of pressure groups and policy entrepreneurs in policy-making is discussed extensively by Kingdon (1994). Buse *et al.* (2012) further argue that health policy is linked with who influences policy and how they exercise their influences. It also includes the conditions under which they act, the funding of health systems, organisation, administration, and evaluation by the state. According to Rhodes, (1990), policy networks approach suggests that there is a shift from government-centred decision-making towards multiple agencies and multiple “sites of discourse generation” (Ball and Exley, 2010). These groups are categorised into highly interconnected policy communities, have limited memberships, and have policy networks, which are looser, larger groups whose focus and shared interests are broader and less influential (Rhodes, 2003).

John (2012) states that policy networks and policy communities have considerable influence on shaping policy outcomes because they can resist the government’s attempts at imposing policies, but they include those in favour of government agendas too (Kingdon, 2011). Ball and Exley (2010) suggest that there is a degree of connections between policy networks and other policy actors and the level of connections influence the level of power. In the Advocacy Network Coalition approach, Sabatier and Jenkins-Smith (1993), propose that actors who play in the policy process share common beliefs, and articulate and promote specific definitions of problems and how to solve them. Forbes (2013) adds that grassroots actors can also serve as policy activists performing equal roles as professional policy entrepreneurs to get specific problems and preferred solutions into the policy agenda. This framework focuses attention on the role of ideas in the framing of issues, learning, and coalition behaviour in policy-making.

The network policy framework has met a lot of criticism, but its importance could not be dismissed, rather it has led to adaptations and developments of the ideas. The research that informs this model indicates that networks and individuals influence the policy-making processes at varying degrees depending on factors such as connections (Ball and Exley, 2010). It is also acknowledged that networks can work within their communities and hence their ideas are affected by their communities. Again, external changes: economy, research evidence, media focus and pressure, and disasters, both natural and crisis events, all shape the context of action (John, 2012).

Ideas and values are central to the policy-making process. Ideas include arguments and debates about the problems that need to be addressed and the preferred solutions. They also include the role of government and various bodies in addressing their agendas. These ideas inform the actions of networks, and other policy actors, as well as shape the wider institutional context. Policy networks communicate ideas through dissemination, speaking, and writing as they create dialogue venues and outlets. Coalition building is key in articulating ideas as it presents a stronger voice (Ball and Exley, 2010). Ideas can represent both a constraint on policy development and a dynamic catalyst for policy change.

Several theories propose that ideas are consciously framed by policy actors in the policy process to suit the preferred solutions. Framing, according to Kingdon (1994) is “underlying structures of beliefs, perception, and appreciation” which influence policy positions. Entman (1993) asserts that framing as an exercise involves the selection of perceived realities and makes them salient and this promotes a particular problem definition, causal interpretation, and proposed solutions. According to McCombs (1997), the selection is usually a restricted number from many alternatives. Government assessment of the framing process depends on access to political actors (which includes government actors) and the presence of powerful allies (Joachim 2003). Farrer et al (2015) assert that framing affects the way an issue receives political attention and how the issue is responded to in policy action terms. It follows then that how a health problem is defined can affect how it is perceived by decision-makers and influence the level of priority it is accorded (Reichenbach, 2002). Framing messages to receive policy-makers’ attention should therefore consider the political environment. Policy frames construct a particular view of social reality and define both the problems and the policy reforms which follow from the framing of the problem. Frames are shaped by the political hierarchies of power and the context of the framing. Politicians likewise frame issues to suit their interests and policy objectives. According to Kalvas *et al.* (2012), different framings have different effects. Corner and Hahn (2009) corroborate the assertion by Kalvas *et al.* that framing might influence the persuasiveness of the message and hence its success and that different framings can elicit different effects.

Framing produces key constructs and orientations around which policy is defined and the context in which policy is made. Meanings to key terms may even differ depending on which actor is using the term. The framing of an issue therefore may differ from actor to actor and it also depends on a particular given situation. Overall, how actors operating within the state, mass media, and wider policy communities and coalitions, frame 'social issues and problems', and associated 'social policy responses' potentially influences policy-making and changes in profound ways.

3.3 Analytical Framework for This Research

The Advocacy Coalition Framework (ACF)

This section introduces key elements of the ACF, and it illustrates how the ACF has been applied in empirical studies. The advocacy coalition framework (ACF) was designed by Paul Sabatier and Hank Jenkins-Smith in the 1980s (Jenkins-Smith *et al.*, 2018). The framework was developed within policy process studies to enrich the analysis of policy change and policy actor behaviour. The framework has been designed to address questions that explain significant policy change and the conditions that drive it forward. These include the conditions under which policy actors form and maintain coalitions to achieve policy aims, the characteristics of the coalitions, and how opposing coalitions interact in the policy process. The ACF also explains the significance and impacts of coalitions in the policy process (Jenkins-Smith *et al.*, 2018). Other questions answered by the ACF are about learning by actors. According to the ACF, people engage in politics so that they can turn their beliefs into policy. They form advocacy coalitions with others with whom they share similar beliefs and compete against those with opposing views.

The ACF as conceived by Sabatier and Jenkins-Smith (Jenkins-Smith *et al.* (2018) seeks to emphasise the key roles and shared beliefs and coalitions of actors in the policy process, but also argues that beliefs can be deep-seated, assumed as well as explicit, and that it is the assumed deep-seated beliefs that often limit the scope for policy change. However, policy actors can be quite unaware of these. For example, beliefs about the role of the state versus citizens in health or beliefs about gender roles in society are often deep-seated and taken for granted rather than explicitly debated in policy coalitions. One key aspect of the ACF argument is that when deep-seated shared beliefs are challenged major policy change can be taken forward by coalitions. Likewise, if powerful groups and coalitions are not willing to challenge deep-seated traditional shared beliefs then advocacy coalitions find it hard to achieve major policy change (Jenkins-Smith *et al.* (2018).

According to Jenkins-Smith *et al.* (2018), on page 139, the central explaining variables of the policy subsystem are key lines of analysis for understanding policy processes and influences on decision-making. The policy subsystem is made up of all organised actors who seek to influence policy and politics in a specific geographical area (Pierce *et al.*, 2017). It includes not only the legislature, executive branch, and organised interest groups but also public officials from various levels and government institutions, scientists, research institutes, journalists, and many others if they participate in the policy-making process or implementation (Weible and Sabatier, 2018). The non-government coalitions consist of experts, NGOs and/or international organisations, journalists, civil society organisations, and/or residents (individuals who are the primary agents concerned by the policies). Coalitions operating within policy subsystems can vary in size, number, and characteristics but, according to Jenkins-Smith *et al.* (2018), what keeps coalitions together are shared beliefs and interests. Coalitions employ strategies and work together but different coalitions are in conflict in these regards. State agencies and powerful policy actors engage with coalitions that mostly share their beliefs, and this involves several levels of beliefs. It involves beliefs that are explicit and constitute the explicit political agenda and those that are taken for granted and deep-seated such as cultural and social beliefs or beliefs about truth and science. State agencies and powerful actors also engage with coalitions that serve their interests and generally are more influential. One understanding of the ACF also expands on the resources needed by the coalitions to affect policy change.

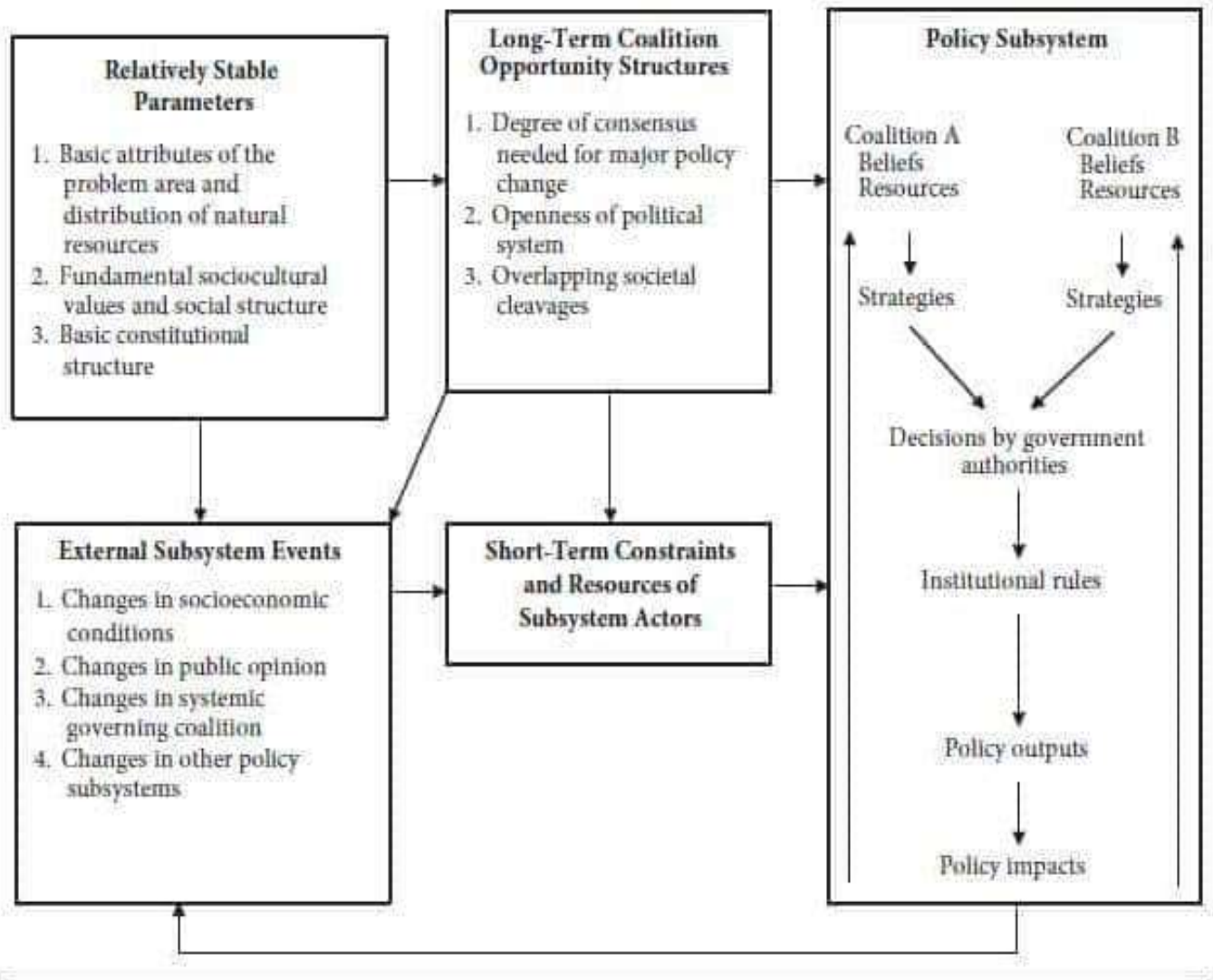
Coalitions hold strong beliefs and are motivated to transfer them into actual policy and develop policy agendas informed by their beliefs in less explicit ways. They hold beliefs about how to interpret the cause and solution of policy problems, and the role of government in solving them. Fundamental social and political views are significant so are more deep-seated as are implicit beliefs such as about sexuality, gender norms, preference for democratic policy change, and commitment to the primacy of legal change.

Nowlin (2011) reiterates Jones and Jenkins-Smith's argument that public opinion affects the policy-making process because public opinion can either act as an external shock and shift the policy landscape, can promote changes in the coalitions as coalition members may shift or can resist radical policy changes. Heinmiller *et al.* (2021) examine policy change in Ghana's information policy subsystem using news media data. The study found external shocks, such as a change in government and adjustment in public opinion, among the foremost factors leading to policy change. ACF theorists have argued that each coalition may revise its beliefs or change its strategy, because of policy-oriented learning. Policy-oriented learning refers to changes in ideas and behaviours in the ways actors pursue goals prompted by learning from experience

(Sabatier 1988). These however affect only the secondary aspects of the coalition belief system and not the core belief system as the primary policy goals remain intact.

Figure 1 below is a flow diagram of the ACF according to Jenkins-Smith *et al.* (2018). The rectangle to the far right, shows a policy subsystem with two coalitions, employing strategies and competing to influence institutional rules, policy outputs, and subsequently policy outcomes.

Figure 3.1- Flow Diagram of the Advocacy Coalition Framework



Source: Weible, C. M. and Sabatier, P. A. (eds.) (2018), *Theories of the Policy Process*, pp.143

The diagram indicates (to the far left) that staple parameters and dynamic external and internal events affect the subsystem activities. In between the above-mentioned variables and the policy subsystem are

intermediary sets of long-term opportunity structures and short-term constraints and resources that also happen outside the subsystem and affect subsystem activities and outcomes.

One of the key criticisms of the ACF is that it was originally developed to understand policy-making processes in the United States and may not suit the policy process of countries with different political structures. However, Jenkins-Smith *et al.* (2014) state that the framework has been used by scholars in other countries. Reviews of the ACF show that from 1987 through to 2014 over 240 studies of the ACF were published in the USA and around the world and the framework has been applied to policy studies of countries with different political structures. Studies related to South Korea, and Sweden have also employed the ACF (Weible, Sabatier, and McQueen, 2009; Jang *et al.* 2016; Pierce *et al.* 2017). Osei-Akoto, Ingold, and Weible (2022) found that 11 studies in West Africa applied the ACF including four in Ghana. It has also been applied to different academic disciplines. Among the areas considered in the studies in African countries were health policy, civil society and governance, and domestic violence policy.

According to Weible *et al.* (2011) in their assessment of 25 years of theoretical developments concerning the Advocacy Coalition Framework, the framework allows for the examination of how, why and with what effect people mobilise, maintain, and act in the advocacy coalition. This thesis draws from the discussion of shared beliefs and hence the ACF is useful in understanding the forming, maintenance, effectiveness, and challenges of women's rights advocacy groups and their campaigns. Questions on the background of organisations in the coalitions, the characteristics of the coalitions, their resources and the nature of their interactions are beneficial to this thesis.

Activism/lobbying in the Modern Age

Alemanno (2017) expatiates on the massive results technology and its associated programmes and products yield to empowering citizens to be able to participate in decision-making that affects their lives. In the current generation, access to technology enables citizens to lobby for change through phone calls, emails, Twitter, Facebook, YouTube, and many other social media platforms. Given a wider audience access in real-time, and connecting people with similar interests around the world, digital attention is converted into meaningful action. According to Garrett, (2006 pp. 211) ICTs therefore 'accentuate traditional movement activities and enable new, virtual ways of organising'. For activists within women's movements, ICTs can communicate their aims and amplify their voices in the public sphere, where women have traditionally been excluded or have struggled to gain influential power.

Fallon & Boutilie (2021) in their research on women's access to technology, concluded that the Internet affects their advocacy. Nartey and Yu (2023) however expand that there are more male users than female users of social media in Ghana. Fallon and Boutilie (2021) claim that in the first decade of the 2000s women's rights organisations in Ghana used e-mail, listservs and websites to mobilise towards the passing of the Domestic Violence Act. However, data indicates that gender equity policies concerning ICTs in Ghana have made little impact, and inequalities are compounded in rural areas. Fallon & Boutilie also found disparities between Civil Society Organisations (CSOs) in the Southern and the Northern part of the country in that the Northern region had limited access to the Internet and had low use of Facebook, websites, and social media. They found as of 2020, only 6 of 16 northern organisations they studied had active websites, and 5 had Facebook pages (Fallon & Boutilie 2021).

The use of social media for advocacy and activism is a new trend in Ghana (Nartey and Yu, 2023). Though it has become much more commonly used and more influential recently, this was not the case during the period when the data collection tools of this study were designed and when fieldwork was undertaken. It is however relevant to consider it in the context of this study since evidence shows that social media may be a critical part of the future of advocacy.

Feminist Standpoint in this Thesis

Patriarchal relations, structures, and systems are at the centre of feminist discourse. The Charter of Feminist Principles for African Feminists (CFPAF) (2007, p.4) defines patriarchy as 'a system of male authority which legitimizes the oppression of women through political, social, economic, legal, cultural, religious and military institutions'. Feminists assert that men's access to resources and their control within the private and public sphere is based on the patriarchal ideology of male dominance (Cusack, 2009). Feminists have also studied how patriarchal structures change over time, and are shaped and interconnected to social class, racialisation of groups, ethnicity, religious beliefs, and global imperial relationships. Feminists' discussions therefore consider the intersectionality of these relations and power dynamics, and their effects on the lives of women and men. According to the CFPAF, to challenge patriarchy effectively also requires challenging other systems of oppression and exploitation, which mutually support each other (Charter of Feminist Principles for African Feminists, 2007).

Gender inequality derives its legitimacy from patriarchal norms, and this affects women's access to representation in the decision-making realms of their countries, access to economic resources, and social amenities (Cusack and Manuh (eds.), 2009). With women constituting a minority of decision-makers,

concerns are raised about the gendered implications of policy-making systems. This can directly raise social justice concerns with, it is argued, patterns of political representation fundamentally connected to issues of distributive justice for citizens concerning “who gets what, where, when, and how” (Easton, 1953 in Waylen (ed) *et al.*, 2013).

Feminist studies have found that absence from decision-making realms coupled with cultural and religious structures affects women’s access to productive and economic resources (Cusack and Manuh (eds.), 2009), a key concern in the feminisation of poverty literature. According to Crenshaw (1991), women’s exclusion from the public sphere cannot be seen as continuous throughout history or as universal. Women’s unequal access to education implies low access to well-paid jobs. No access to landed property (as many women do not inherit land in Africa) implies low access to economic resources including credit facilities from financial institutions to enable women to accentuate their rights and make decisions that would improve their lives. Male dominance of economic resources affects women’s access to life-based amenities including healthcare and for that matter reproductive health. According to Waylen (ed) *et al.*, (2013), emphasis is put on the women’s provision of sexual, emotional, and active services that are required to maintain family and intimate relationships, but these remain unacknowledged as work, and these are sources of gender inequality.

Feminist studies have examined how male dominance in society can foster abuse of women physically, sexually, emotionally, and psychologically. Crenshaw (1991) asserts that the violence experienced by women of colour is not physical only, but that the physical is evidence of their economic subordination in relationships. In the Ghanaian context, Akumatey and Darkwa (2009) argued that women’s inability to decide for themselves how their reproductive rights should be exercised leads to reproductive health challenges as they are not able to access healthcare because they do not have control over their financial resources or over shared family joint-created resources. According to Akumatey and Darkwa (2009), women can be limited in their capacities to decide the ‘how’, ‘where’, and ‘when’ of their reproductive activities. Feminists have explained and challenged these patterns of male dominance.

Women have organised to demand their rights in virtually every country in the world, though with varying degrees of success. African women have participated in and led the struggles of their nations and the emancipation of women across the continent in the context of struggles against colonialism, slavery, and globalisation (Adomako Ampofo, 2008; Bakker, 1994). These struggles have questioned patriarchal structures that keep women dominated.

Policy Entrepreneurs and the rationale for the use of Kingdon's model despite its limitations

Cobb (1985) states that the most notable contribution of the policy stream framework is the creation of new terms like policy entrepreneur. Kingdon (1984) argues that policy entrepreneurs are adept at identifying and acting to influence policy change during windows of opportunity. A key asset of policy entrepreneurs is their ability to integrate and understand the three policy streams - the policy stream, the problem stream, and the political stream.

One of the key criticisms of this theory of agenda-setting is the tendency to individualise policy entrepreneurship. In Kingdon's agenda-setting theory, the concept of the policy entrepreneur is as much about the individual actor (entrepreneur) as it is for the process (entrepreneurship), making the individual actor key to Kingdon's agenda-setting theory. Oborn, Barrett, and Exworthy (2011) investigated the role of the individual expert actor in London's healthcare reform. The authors found that the dominant entrepreneur forges alliances between different actors and policy communities. However, they argue entrepreneurial actions and impacts are related to collective actions. According to Mintrom and Norman (2009), policy entrepreneurs who have access to networks have increased chances of achieving policy outcomes. Policy entrepreneurs understand that their networks represent repositories of skill and knowledge that can support their initiatives.

The agenda-setting theory neglects advocacy coalitions as conceptualised in the ACF. However, the ACF recognises the policy communities, and the role of collective action played by coalitions in securing change. Kingdon (1984) however does not stress this in his agenda-setting theory.

Kingdon (1984) is criticised for neglecting supranational policy contexts. Hill and Irving, (2020), indicate that Kingdon is too general in his analysis of the agenda-setting process and is ambiguous about the role of international actors. According to them, Kingdon (1984) assumes the nation is primary and that all nations are equal in their capacity for autonomous sovereign decision-making. However, policy choices and agenda-setting within nation-states in the Global South are often influenced by external policy actors including international institutions and interest groups (Hill and Irving, 2020). Cherlet and Venot (2013) in their study of the water policy-making process in Burkina Faso, a country in West Africa, evidenced the involvement of international bodies like the Danish International Development Agency (DANIDA) in the policy-making

process of the country. Likewise, Ghana, being a lower middle-income country, depends on international bodies for part of its healthcare funding and this often impacts the policy-making process.

One of the key criticisms of Kingdon's agenda-setting theory is the neglect of gender issues in the agenda-setting process. Kenney (2003) asserts that Kingdon offers little attention to the problem stream. Feminists would want to know how something like gender-based violence came to be seen as a problem that can be solved by public action rather than merely a condition. According to Kenney, feminists are particularly interested in the social construction of problems related to gender inequality but this process appears to not feature highly in Kingdon's theory.

The usefulness of Kingdon's multiple streams framework to this research is found in its ability to provide useful insights into the research questions such as how advocacy groups construct and frame the problem of inadequate reproductive health rights and services, indicating why some issues, problems and concerns become prominent agenda items and why others fade out. The problem stream focuses on identifying and defining the key problems and possible solutions and alternatives. The multiple streams framework by Kingdon (1984) also supports the research question of what the tactics/strategies used to achieve advocacy outcomes are.

Kingdon's theory explains that for a solution or policy alternative to be selected, it depends partly on the persuasiveness and the ability of a policy entrepreneur to adopt and make a case for the proposed solution or policy alternative. This thesis explores how women's rights advocacy groups use their skills and resources to influence policy-making by proposing alternatives and preferred solutions.

The Agenda setting theory provides the avenue to discuss institutions involved in the policy-making process outside government consisting of interest groups such as the women's groups that this study is focused on (Tandoh-Offin, 2010). Kingdon's theory of agenda-setting also provides avenues to discuss resources available to the women's groups in Ghana and the strategies they employ to advocate for policy change as policy entrepreneurs. Also, discussions of the national mood and public opinion are relevant as these would be discussed to reflect on Ghana's political, economic, and sociocultural context.

As mentioned earlier, Kingdon's model is less able to provide insights about the role of networks and coalitions which are vital ingredients in civil society participation in public policy in Ghana and other emerging democracies. Again, it provides few insights about gender relations and political power. This

explains why the discussion of the Advocacy Coalition Framework and the gender theory of inequality, are necessary to complement the agenda-setting theory for this research.

3.4 Policy Implementation

Barrett and Fudge (1981) view the relationship between policy and implementation as an interactive process. According to Newman (2002), the policy-making theories and analyses recognise key processes, not only agenda-setting, problem framing, and policy formulation but also implementation. Pressman and Wildavsky (1988) note that a policy appeal should not only be measured by its formulation but by its implementation also because at the level of implementation many decisions are also taken which have the potential to make the policy a success or a failure. A key element mentioned by the authors is the interest groups' participation in the design stage as critical in the implementation of the policy.

3.4.1 Top-Down and Bottom-Up Approaches to Policy-making

According to Matland (1995), top-down models of implementation consider centrally located actors as most relevant to producing the desired effects of policy. Jenkins-Smith and Sabatier (2008) do not agree with the depiction of policy-making as top-down sub-processes or stages flowing from agenda-setting to policy formulation dominated by government leaders. DeLeon and DeLeon (2001) point out that top-down theories may encourage the implementation of standards that citizens do not understand, which might also overlook their rational preferences. One of the major criticisms is that the top-down approach could not be applied to areas of distinct policy or areas where policy overlaps and hence the bottom-up approach is offered as realistic in policy implementation. Lipsky's (1980) study on public servants concluded that street-level bureaucrats including social workers, health workers, and legal-aid lawyers interact directly with the public. Working on the high number cases and inadequate resources, their decisions, and actions during implementation affect policy. The decisions made by street-level bureaucrats translate into policy either consciously or unconsciously and hence allowing them discretion in the implementation process has an impact on the success of the policy implementation (Pressman and Wildavsky, 1984; 3rd edn; Matland, 1995).

The approach demonstrates that the decisions of public servants referred to in Lipsky's study as street-level bureaucrats, constitute policy directly or indirectly. It acknowledges the role of what is referred to as 'frontline agencies, bureaucrats, and professionals' in policy enactment and delivery. For a decentralised system of governance, the bottom-up approach is suitable for considering policy implementation at the district and regional levels in Ghana. It opens a door for an approach to analysis advocacy at the district and

regional levels where the focus of interaction is not only with politicians but also duty bearers. Klugman (2011) adds that grassroots actors (communities and target groups) also serve as effective actors performing roles equal to the policy entrepreneurs in Kingdon's policy stream theory to get specific problems and preferred solutions into the policy agenda. This research work, using this framework, will discuss the nature of advocacy in Ghana and the position of advocacy groups including grassroots actors in the policy-making process. Lipsky (1980) argued that the government has taken part in the role of charity for example, by paying the poor and hence street-level bureaucrats do not have much work to do. This may be context-specific in the country of his study. It does not apply to the Ghanaian context. NGOs including women's rights advocates in Ghana, continue to deliver critical services as they work alongside local government service workers at the community, district, regional and national levels.

3.5 Kingdon's Theory of Agenda-Setting

Kingdon's (1984) theory of agenda-setting is a modified theoretical model of the policy-making process and policy change that draws on prior theories such as "the Garbage Can Model" proposed by Cohen, March, and Olsen in 1972 (Rawat and Morris, 2016). It is usually referred to as the Kingdon 'streams model'. Agenda-setting, according to Kingdon (1984), is the process by which 'problems and policies' either gain or lose the attention of policy-makers. Kingdon (2011) refers to agenda as the conception of the problem and what is viewed as a political and policy priority. The issues are conceived as problems and other elements of the problems, understanding of the causes of the problem, symbols, solutions, and how these come to the attention of government officials and the public. Kingdon argued that three factors; participants, process, and social and political context, determine the noticing of an idea by policy-makers and their subsequent action. Participants are made up of what Kingdon terms policy entrepreneurs.

According to Kingdon, there are three streams in the policy-making process: problem, policy, and politics. The problem stream deals with the characteristics of problems and how they are perceived as public issues that call for government attention. These problems come to the attention of officials through reports, statistical indicators, feedback from programmes, agendas of governments and their ideological agendas, pressure, and advocacy groups.

The policy streams consist of the generation of solutions and their alternatives usually presented by researchers, advocates, NGOs, and politicians. The policy stream is therefore filled with outputs of experts whom Kingdon calls policy entrepreneurs. Many policy alternatives are suggested and reduced to a few feasible options (Beland and Howlett, 2016).

The Political stream refers to political events such as campaigns, swings in national mood, changes of government, legislature, and elections. The combination of these issues shapes the stream by providing the context for policy-making. The national mood represents the common lines along which the larger number of people think and is affected by changes in opinion and campaigns by pressure groups. In other words, the public opinion creates a national mood. Kingdon's study reveals that pressure groups make an impact if they have good leadership and are well organised (Kingdon, 2014). Administrative changes in government including a turnover of the legislature also affect which agenda is pushed on the policy table and which becomes stale.

Though all three streams (problems, policy, and politics) run parallel, a policy window may open when all three streams are indicating the same solution and a high priority need for action and when the broader context makes this possible. At that stage, an agenda is set. However, policies can also be enacted without a policy window when governments already place a high priority on a certain action. Advocates could help to create the policy window of opportunity and it is an opportunity for advocates to push for attention to their problems. A favourable policy stream opens when political actors who take advantage of opportunities to influence policy decisions (policy entrepreneurs), manage to link solutions to the public problems at the time when public attention, political majority, and demands of society provide a favourable context for the development of policies.

Figure 2.2: Agenda-Setting framework



The first step in policy-making is for the issue to gain a place on the policy agenda. The process and outcomes of ‘the agenda-setting phase’ is one of the determinants of why a particular policy is adopted and others are not (Seddoh and Akortey Akor, 2011). Kingdon (2011) states that political actors’ conception of

the problem is informed by the problem and the policy stream as they try to set the agenda and fall on fewer actors like interest groups and academics for alternatives from which authoritative choices can be made. Potting (2009) corroborates Kingdon's view that during the agenda-setting stage, advocates engage in very detailed discussion on how issues should be framed and presented, even concerning the naming of the agenda item and they are important actors (policy entrepreneurs) across all three streams.

Kingdon's theory is based on research he conducted on health and transportation policy areas in 1976, 1977, 1978, and 1979 in the USA which has a federal governmental system. He interviewed 247 congressional staffers, the executive branch of political appointees, upper-level civil servants, and presidential staffers. He also studied government documents and written materials. Kingdon found out that there are many actors in the policy-making process, and all have influence at various stages. However, the President and his appointees have great influence in agenda-setting. Congress is good at agenda-setting and specifying alternatives from which the choice is made. The rest of the actors (social movements and Civil Societies, policy and campaigning networks, research and scientific communities, consultants, Trade Unions) are also influential in the alternative specification. Kingdon refers to these actors outside the government institutions as policy entrepreneurs. Policy entrepreneurs are advocates who are willing to invest energy, time, reputation, and money to promote a position in return for anticipated future gain. They proffer policy alternatives and fuse them with problems to present solutions to policy-makers at the right time (Mintrom, 2019). Kingdon's findings however indicated that if the media was conceived as an independent actor, they were not independently influential in pursuing distinct agenda. But McKeever (2012) in research on how the media influenced the public agenda on autism, concluded that the media was influential in shaping the public health agenda, increasing funding, and raising awareness. This is because "news framing involves selection and emphasis of certain ideas or aspects of issues in news coverage to promote salience among the audience" (McKeever, 2012 p215). In media advocacy, groups identify, define, and frame a problem to fuel media reportage of the problem as a public health issue. Gibson (2010) conceptualises that media advocacy consists of three steps: (a) setting the agenda, (b) framing the issue, and (c) advancing a solution. However, as participants in the policy process can overlap, media stories can also be promoted by others to make them more influential.

According to Bundgaard and Vrangbak (2007), many scholars have discussed the potential problems or limitations of Kingdon's theory. They argue that the role of policy entrepreneurs is not well defined in Kingdon's theory and that he did not theorise the diversity of this group. A total view of policy entrepreneurs

is therefore not presented. Bundgaard and Vrangbak (2007) therefore propose the separation of policy entrepreneurs into different tiers: a lower level and an upper level in the policy process.

3.5.1 Applying the Theory of Agenda-Setting in Ghanaian Policy Development

Liu and Jayakar (2012) noted that Kingdon's theory is applicable to democratic and deliberative policy contexts only and it is not easily applicable to the policy process of some developing countries because the political structures are not the same as the Western political structures or the federal and unitary political systems of the USA. For example, the political structure in China is different from that of the Western countries and hence the three streams discussed by Kingdon and their coupling may not happen in China. Cherlet and Venot (2013) corroborate those structural conditions determine the strategies that policy entrepreneurs use. In their comparative study of Burkina Faso and Mali, they found that international organisations play major roles in determining how these countries accept policy change, but international actors are not recognised as significant enough in Kingdon's model.

Similarly, Beaussir (2017) applies Kingdon's theory to study the agenda-setting of health insurance in Burkina Faso, a country in West Africa. He advances reasons why Kingdon's theory may not wholly apply to the African Policy environment. There are political and institutional obstacles that reinforce the weight that is produced by the different contexts and systems in the West African political environment. The low level of literacy, fragmented civil society that is remote from politics, abject poverty, and fragile democratisation after the coup, become challenges in translating Kingdon's theory. Beaussir's findings corroborate that of Charlet and Venot (2017) that heavy reliance on international policies and external funding from donors and world institutions implies that actors must consider the international context and opportunities to push for policy implementation.

Though Beaussir's study is in West Africa, it can be argued that not all the obstacles mentioned apply to the Ghanaian context. Though civil society in Ghana was also weak during the PNDC era (military state, 1979-1992), it has strengthened and expanded since the 4th Republic in 1992 (WACSI, 2015). The heavy dependence on international funding with its conditionality mentioned by both Beaussir (2017) and Cherlet and Venot (2013) however applies to the Ghanaian situation. For example, a joint evaluation of multi-donor budget support to Ghana conducted by the Ghana Centre for Democratic Development (CDD) (2007) provides that in 2003, the Official Development Assistant transferred to Ghana a sum that amounted to US \$300 million and this constituted 13% of government spending (CDD, 2007). This affects the health sector of the country as the sector depends heavily on external funding.

The limitation identified by Liu and Jayakar (2012) can be questioned as applying to several developing countries. Ghana's political structure by constitution is a hybrid arrangement. It combines features of both the US presidential system of Government and the British Westminster system of Government (Sefa-Nyarko, 2021). It therefore has some commonalities with the political environment in which Kingdon conducted his research. There is still a policy-making process by government and government institutions. The legislature (parliament) which is the arm of government responsible for law-making still engages in its core business. Though the conditions of international political and funding groups impact decision-making, there is still room for policy drafting and the legislature and various national actors potentially could get involved. Kingdon's theory of agenda-setting, therefore, provides an adequate theory on policy-making for this research.

Kingdon's theory of agenda-setting recognises the role of civil society actors in the policy-making process (Seddoh and Akotey Akor, 2012). Though it did not theorise the types of Civil Society organisations, it still provides one useful theoretical framework that will be employed in this study. Irrespective of the limitations put forward in Kingdon's theory, it is relevant to the study. Though the theory needs to be developed according to the context it still provides a useful framework for analysing the policy-making process, its various streams and actors, policy windows, and policy entrepreneurs.

3.6 Social Policy Advocacy

The theories reviewed acknowledge that advocacy is a critical part of the policy-making process (Kingdon, 1984; Sabatier and Jenkins-Smith, 2008; Ball, 2012). Advocacy can be defined as a process that involves the promotion of a set of actions to introduce or change policies and programmes in particular ways. Advocates promote the interests of particular groups and, when concerned with social justice, human rights, and social rights. In practice, advocates promote a position such as via lobbying and addressing legislators to influence their votes. Hill (2014) states that policy advocacy includes pressing specific options and ideas in the policy-making process, either individually or in association with pressure and interest groups. According to Farrer et al (2015), health advocacy means the promotion of specific actions and policies that improve access to health by all. Paramoer (2015) expands the definition and states that advocacy is on health efforts that influence health systems and the social and structural elements of health.

Advocacy can vary along progressive and conservative dimensions or rights-based and needs-based approaches. Progressive advocacy groups press demands for the government to provide basic needs for its

people, promote their rights, and protect their self-esteem. Diamond and Liddle (2015) consider how civil society advocacy groups and collective organising reflect resistance to structural forces and thereby prevent the state and the market from becoming the ultimate source of collective power in ways that can be detrimental to the well-being of citizens. The needs-based approach to advocacy is considered the traditional community development response that seeks to identify the needs of communities and to seek ways to work together with such communities to solve their issues by providing services and assistance (Edmund Rice Centre, 2013). In a rights-based approach, advocates focus on what rights are being neglected and work towards holding duty-bearers accountable (Schmitz, 2012). This requires a process of empowering communities to identify their rights and seek justice. The approach emphasises the role of inequalities in creating poverty and its associated non-access or limited access to social amenities. The literature, therefore, views advocacy actions as influencing policy formulation and implementation in a range of ways. A structured advocacy plan, therefore, has a purpose to start, direct, or prevent a specific policy change. Progressive advocates often seek to challenge conservative and neo-liberal reforms.

3.7 Evidence-Based Advocacy and its implications for advocacy

The Multiple Streams approach of Kingdon accommodates evidence as an element that requires active interpretation to become defined as ‘problems’. According to Alison *et al.* (2018) evidence, research, and other types of knowledge occupy space in the problem and the policy (alternatives) stream. An almost infinite number of problems could be considered in the problem stream. Kingdon’s interest is in how certain problems come to the attention of policy entrepreneurs and are regarded as important by stakeholders (Kingdon, 1995). Focusing on events, feedback, budgets, and indicators are all mechanisms by which this occurs.

In this research, the interest is on the importance of evidence in the advocacy process and the useful types of evidence. In recent times, evidence has been discussed as critical for successful advocacy and superior to ideological and moral arguments (Storeng and Behague, 2014). According to Alison (), the evidence-based policy paradigm concentrates on identifying “what works” and then facilitating the translation of this scientific evidence to policy decision-making. Greve (2017) refers to evidence as knowledge about the effects of social policy or initiatives which are produced through randomized experiments or synthesis. However, evidence generated through qualitative approaches, though it has not been accepted by many, is also fit for use (Farrer *et al.*, 2015). Wessel (2018) states that qualitative inquiry uncovers aspects of social reality not found by the quantitative forms of inquiry. This is because policy discussions are usually value-driven, not just evidence-based choices (Fadlallah *et al.*, 2019). Knowledge could be derived from science

but interpreted and reframed in the policy development process as lay knowledge, practitioner knowledge, and policy-makers' intuition. All these forms of knowledge may come to bear on policy-making. According to Storeng and Behague (2014), evidence makes health policy objective and economical and hence a better basis for pursuing cost-effective policies. Farrer *et al.* (2015) established that social policy evaluations and cross-cutting sectoral initiatives seek to examine and evaluate the impacts, costs, and benefits of policy actions and inactions; the differential outcomes of policies; and propose theories of policy effectiveness based on empirical studies. The knowledge and evidence generated provide key types of 'evidence' considered and employed by advocates, such as healthcare and health services advocacy.

The ACF, however, claims that the development and availability of relevant and robust scientific theories and research are not sufficient conditions for policy change. As set out above, values, interests, power relations, and assumptions are always present in policy-making. The evidence-based policy movement is further criticized that it can be biased, and the study may lack integrity because beliefs and attachments for certain values penetrate the stages of the study and how studies are interpreted and considered in the policy-making process. Claims of being evidence-based can therefore obscure and hide the significance of cultural and social assumptions and values in scientific, research, professional, and policy communities. The importance and use of research evidence and scientific claims in advocacy, therefore, needs critical assessment. Monaghan and Ingold (2019) based on a study on advocacy, propose that the use of research evidence and scientific knowledge may also reflect the capabilities of the advocates who gather and employ this evidence. The use and employment of research evidence, scientific knowledge, and claims to be 'evidence-based' are therefore key research questions for the study of advocates and policy-making.

3.8 Movement/Alliances and Coalition Building

Cullerton *et al.* (2018) in their review of works on trauma care assert that collaborative action is critical to effective advocacy. Coalitions bring organisations and communities together to put their resources together toward a common policy goal (Honeycutt and Strong, 2012). According to Viterna and Fallon 2008, movements, alliances, and coalition building help in preparing platforms and pushing political parties and state officials to adopt the platforms through lobbying, protests, and media campaigns. (Coalition/movement building provides non-government organisations with people's power in information, resources, and expertise. It is not only the "mass voices" that are gained, though that is important, there is also the benefit that the quality of the "mass voices" is present. The expertise that the coalition helps to garner, human and financial resources that are brought on board and the contacts and networks of each organisation become great assets to the coalition. Honeycutt and Strong (2012) in their research on coalitions and their work

towards health insurance in the USA, found that access to resources was significant. From the documentation, as evidenced by Adomako Ampofo (2008), the Ghanaian Alumnae of Female Lawyers (LAWA) started the action on Domestic Violence Law, but within four years, the coalition included the Federation of Women Lawyers (FIDA). Other organisations and individuals like Women's Initiative for Self-Empowerment (WISE), a rights-based NGO, politicians, and NGOs who were into women's reproductive health also joined. The synergy produced by the expertise of these various backgrounds ensured a successful advocacy activity. In qualitative research on funding of NGOs, the Ark, an NGO, stated that "*Networking has been quite significant. The idea that you are not alone..., that others care about issues, is helpful*" (Apusigah *et al.*, 2011 p. 71).

According to Joachim (2003) who studied NGOs in international advocacy, one of the key considerations in mobilizing is the capacity of actors to engage in deliberative and innovative knowledge sharing and have unique contributions to make to the new structure. According to Joachim (2003), to promote women's rights, the ability of women's movements to build coalitions across class, race, ethnicity, and political affiliation is critical. This is because these social factors play important roles in the kinds of issues people organize around and how these movements act together for change (Viterna and Fallon 2008). According to Joachim's (2003) review of the key findings and ideas from studies of advocacy shows that the ability of the advocacy group to build a strong coalition inclusive of all social classes will also determine how representative the coalition is and this affects interest, and inevitably, the ability to communicate that the issues being mobilized around are representative of all members of the constituents around whom the issues affect. Kingdon's (2014) study also concluded that social movements need organisation and leadership to make an impact. According to the study done by Honeycutt and Strong (2012), organisations having an existing relationship with policy-makers offer quicker access to forging a new policy-maker relationship.

3.9 Women's Advocacy Groups in Ghana and the Policy-Making Process

Women's advocacy groups that are the focus of this research are Non-Governmental Organisations (NGOs). NGOs are not-for-profit organisations and their activities including advocacy are towards community development and social justice. NGOs are usually discussed within the broader spectrum of Civil Society Organisations (Carothers, 1999). Civil Society refers to associations and groups that exist apart from the state and the market (Powell and Steinberg 2006). It, therefore, excludes organisations with profit-making motives. Civil society organisations have been present in Ghana since the 17th century but became weak during the post-independence era when citizens could not voice their opinions (WACSI 2015). Civil society

in Ghana, however, emerged as an important political and socio-economic player at the beginning of the 4th republic (Apusigah, Tsikata, and Mukhopadyay, 2011).

The West Africa Civil Society Institute (2015) which undertook a survey in Ghana in 2015, established that there were over 4,920 Civil Society Organisations in Ghana (WACSI, 2015 p.25). According to Atibil (2012) who researched State–Civil Society Relations in Ghana from 1982–2000, civil society organisations are undertaking diverse policy influencing roles; some are into research, others are into lobbying, and yet others do campaigns and education on various social topics. They fill in the developmental gaps of their governments. Civil Society includes a variety of coalitions, networks, faith-based organisations, and NGOs. Antwi-Bosiako (2019) adds that CSOs in Ghana are involved in national development discourse, poverty reduction initiatives, and monitoring of government policies. They represent their constituents and ensure free, fair, and equitable access to resources.

The research done by the West African Civil Society Institute (2015) indicates further that in Ghana, some NGOs are involved in advocacy only, whilst others do advocacy and deliver services.

Bratton (1989) defines NGOs in 3 categories:

- Community-based associations are small, have close membership, and rely upon modest resources.
- National level NGOs may be either membership or service organisations with small professional staff.
- International relief agencies are service organisations.

These categories help to understand advocacy groups in Ghana and to theorise potential policy networks. Women's groups in Ghana have mobilized toward making domestic violence a crime (Adomako Ampofo, 2008). They have also worked in the past to criminalize Female Genital Mutilation (Ako and Akweongo, 2009). The abortion laws of the country have been liberalized to reduce unsafe abortions and consequently needless deaths among women of reproductive age (Jehu Appiah, 2009). It can be argued that women's rights advocates engage in advocacy in various areas of health and human rights.

Literature evidence that funding for Civil Society groups is a challenge. Apusigah, Tsikata, and Mukhopadyay (2011) assert that funding for Civil Society organisations' work in rights and social transformation has declined. Antwi-Bosiako (2019), in his qualitative research on Civil Society Organisations' (CSOs) participation in governance in Ghana, found that most CSOs depend on international

or foreign donors for funding for their work. Boadu (2019) came to a similar conclusion in her study on the impact of CSOs into gender equality and stated that dependence on donor funding leads to CSOs accounting more to their donors than the communities they serve. The lack of adequate funding for CSOs and the fact that most CSOs receive funding from the same donors, creates unhealthy competition amongst them (Boadu, 1999).

3.10 Advocacy by Women's Rights Advocacy Groups and the Agenda-Setting Theory

It can be argued therefore that NGOs draw attention to their issues by engaging in a strategic framing process. Uzochukwu *et al.* (2020) researched what makes advocacy on maternal and child health programmes work in Nigeria. They found that women's rights advocacy groups take advantage of triggers such as the government's withdrawal of subsidies and the windows of opportunities they present, and as policy entrepreneurs, push the agenda for policy-makers' attention. This is useful when they can take advantage of the window of opportunity by addressing multiple streams simultaneously. Women's rights advocacy groups select and employ strategies that will increase the likelihood for their chosen agenda to get attention and translate into policy or laws (Jansson, 2016). As indicated earlier, there is not much research on women's rights advocacy in reproductive health in Ghana. This research is therefore to fill this gap.

3.11 Conclusion

The chapter has reviewed theories of policy-making, and situated the research in social policy, and health policy as policy fields. It has also identified advocacy groups as part of the policy actors. The review of concepts and theories of social policy reveals that not many of these works are based on evidence from Africa and hence the claims of many writers may not apply the same way in the African context or the Ghanaian context. Irrespective of this, the agenda-setting theory by Kingdon has been presented as being fit to provide the structure for analysis as this research highlights the Ghanaian-specific contexts. With the agenda-setting by Kingdon and gender inequality as theoretical frameworks, the research will explore the politics of violence (gender inequality) and how women's rights advocacy groups take advantage of the political levers in Ghana to advocate for policies that enhance women's reproductive health and repudiates gender inequality as a contributing factor to the state of women's reproductive health.

The next chapter is the methodology chapter that encapsulates the design and analysis of data that the literature reviewed would be used to situate in the scholarly domain. The chapter starts with the epistemological stands of qualitative research and then discusses the choice of methods for both data collection and analysis.

CHAPTER 4: METHODOLOGY

4.0 Introduction

This chapter states the research aims, objectives, and questions. This is followed by an outline of the epistemological standpoints which informed the research design. Interpretivism, constructionism paradigms and feminist standpoint are provided as the paradigms that informed the choice of methods. The chapter explains and justifies these methodologies and empirical stands. The chapter also gives an outline of the research methodology. Data collection methods and approaches have also been outlined, considering ethical issues, challenges, and reflexivity throughout the research process. The implications of feminist and interpretivist influences whereby the research sought to engage with and analyse a range of perspectives and organisations are discussed. The chapter ends with the data analysis.

4.1 Research Aims, Objectives, and Questions

4.1.1 Research Aims

This thesis aimed to examine, from the perspective of those engaged in the processes and practice, the role of advocacy groups in reproductive health policy formulation and implementation in Ghana, examining also the link between violence against women and women's reproductive health. It explores the policy-making process by identifying the key issues, strategies, actors, and power dynamics at play during the process.

4.1.2 Research Objectives

The research addressed the ways in which advocates themselves and policy-makers understand and position the roles of advocates and perceive their impacts and challenges. The objectives of this research are therefore to:

- Examine how those involved in leading and practising women's rights advocacy perceive and experience their roles and actions within all phases of the policy process.
- Explore how those involved in reproductive health and violence against women advocacy act as individuals, members of organisations and members of coalitions throughout the policy process.

These objectives have emerged throughout the study. At the onset of the study and as an advocate myself, I was most interested in women's sexual reproductive health and rights and hence the objectives did not explicitly include violence against women. This focus however developed through critical engagement in

the literature to be reformulated to include violence against women to allow the discussion of how violence affects women's reproductive health.

4.1.3 Research Question(s) to be Answered

Main Questions

- How and why do women's rights advocacy groups and other policy actors conceptualise and frame the relationship between women's rights, gender inequality, violence against women and reproductive health rights in the Ghanaian context?
- Analysing the perspectives and experiences of women's rights advocacy groups and other policy actors, how do they pursue and practice advocacy in this area? And what influences effectiveness and impact?

The sub questions are:

- How do women's rights advocacy groups conceptualise and evidence the relationship between violence against women and women's reproductive health during the advocacy processes?
- How do women's rights advocacy groups construct and frame the problems of inadequate reproductive health rights and services and violence against women; and the proposed/preferable policy changes and alternatives?
- From the perspectives and experiences of women's rights advocacy groups and policy-makers, how do resources, relationships and context influence the advocacy process and impact?
- What are the tactics/strategies used to achieve advocacy outcomes?

4.2 Research Methodology

4.2.1 Paradigms and Approach

The research paradigms that informed the choice of methods are interpretivism, constructionism and feminist standpoint. Paradigms determines what is to be examined and what counts as relevant data for answering research questions, interpretation of the data and the structure of presentation (Perry and Bellamy, 2012). The choice of paradigms therefore had an impact on the way data was collected and analysed. But methodology goes beyond the paradigms. It is both the underlying theories and standpoints of what constitutes valid social science knowledge and what that knowledge contributes to our understanding of the social world (Klein, 2007; Tashakkori and Teddlie, 1998; Becker *et al.*, 2012). For example, the interpretivism paradigm seeks knowledge about the nature and implications of meanings, subjective experiences and perspectives because this influences our actions.

4.2.2 Interpretivism

Interpretivism is based on the idea that society does not exist in an objective, observable form but rather is experienced subjectively because people give meaning by how they behave and perceive things. This implies that social phenomena cannot be measured simply in variables and facts like the natural sciences as we are constantly interpreting meaning, explanations, and perspectives because knowledge is value-laden (Petty *et al.*, 2012). Again Somers (1994) asserts that ontological narratives explore who we are and provide the basis for what to do. In other words, rather than seeking an objective perspective, interpretivists look for meaning in the subjective experiences of individuals engaging in social interaction. Interpretivists researchers immerse themselves in the social context they study because the values and beliefs of researchers cannot fully be removed from their inquiry (Tashakkori and Teddlie, 1998). Again, interpretivism is relevant to this study because of the political and cultural representations and discourses and their role in reinforcing or challenging power relations in society at all levels. Thus, providing the paradigm for highlighting the link between ideas, values, constructs and power.

4.2.3 Constructionism Paradigm

The main tenet of constructionism theory is that knowledge is not given but constructed. Social constructionists claim that all knowledge is built up by interaction among members of a group or culture (Burr, 2015). Social constructionism posits that meaning, notion, or connotation is placed on an object or event by a society and adopted by the inhabitants of that society concerning how they view or deal with the object or event. This means that the shared experiences of the members of society influence their perceptions and actions. People make their social and cultural worlds at the same time these worlds make them (Galbin, 2014).

4.2.4 Feminist Standpoint

Feminist standpoint theorists claim that an individual's lived experience, her place in the world and culture informs and builds her reality and how she understands her position and the larger sociocultural world she/he lives in (Weisman, 2017). Therefore to the feminist, like the constructionist, knowledge is socially situated. Marginalized groups are socially situated in ways that make it more possible for them to be aware of things and ask questions particularly which focus on power relations. By so doing, they find a voice. Initial enquiry in women's lived experiences, mediated by the politicized consciousness that emerges within a feminist standpoint, reveals the way in which male-dominated ideologies distort reality. Standpoints make visible aspects of social relations and of the natural world that are unavailable from dominant perspectives, and in

so doing they generate the kinds of questions that will lead to a more complete and true account of those relations. These questions are informed by many locations, including race, sexuality, age, social class, and gender (Crenshaw, 1991).

Feminist standpoint theories place relations between political and social power and knowledge centre-stage. These theories describe and analyse the causal effects of power structures on knowledge while they also advocate a specific route for enquiry, emerging from shared political struggle within marginalised lives, and bringing about change which results in more just societies. Feminist standpoint theories have advocated taking women's lived experiences as the beginning of scientific enquiry.

4.2.5 Application of Paradigms in the Thesis

Paradigms are resources from which to pose important questions and to explore social processes and phenomena. This research as stated is about reproductive health policy-making. According to Mayhew (1998), health policy processes and analysis require a flexible research approach. Qualitative methods are particularly useful for policy analysis to better understand and inform the contexts in which decisions are made, and the interactions between actors at different levels to clarify the ways power and participation are negotiated. Using Kingdon's policy stream analysis of agenda-setting and feminist theories of gender inequality, qualitative research allows an understanding of the context (Bryman, 1988). It helps to answer questions of how and why (Baum, 1995). Feminist researchers have therefore encouraged the involvement of the researcher in the research process who can bring personal experiences to bear on his/her study. Interpretivism, constructionism paradigms and feminist standpoint theories therefore, provide the epistemological stands for qualitative research. The use of interviews allows the subjective views of participants and acknowledges the role of the researcher at the centre of the research and her knowledge and experiences influence the knowledge being created. The interviews provide rich contextual and in-depth information on the role of the population being studied in the policy-making process in Ghana. The feminist standpoint accommodates the discussion on the power relations and its relevance in the policy-making process especially in constructing knowledge about marginalised groups and their experiences.

4.3 Data Collection Methods and Approach

Churchill and Sanders (2007) state that different types of data require different ways of capturing the phenomenon being researched. According to Thomas (2003), qualitative research refers to collecting and interpreting information about some phenomenon without concern for quantities. Qualitative research intends to understand and explain social phenomenon through analysing experiences of individuals and

groups, interactions and communication among a group or analysing documents. Qualitative research therefore analyses how people construct their world and their experiences that provide rich insight (Flick, 2007). According to Becker *et al.* (2012) qualitative research focuses on ‘actors’ and the meanings they give to their actions, and also it is concerned about descriptions, context, process and flexibility. The research objectives and questions indicate that the research analyses women’s rights discourses and actions in the Ghana context. It also explores the interactions between women’s rights advocacy groups and other policy actors, hence there is a need to employ a qualitative methodology rooted in appreciation of the importance of understanding women’s rights issues and women’s experiences and positions.

Adaption of Research Design and Data Collection Methods from Mixed Methods to Qualitative Methods

Initially the research was designed to employ mixed method for the data collection and analysis. The decision was premised on the knowledge of lack of quantifiable data in this field of advocacy in Ghana. The choice of mixed method therefore was to add quantifiable data that will provide general and indicative trend data and to provide that broad context for the data from the interviews. A Survey was therefore planned together with the semi-structured interviews.

Survey Sample and Selection

The target population for the survey were individuals in leadership positions within identified women’s rights and reproductive health advocacy groups and organisations. This sample group was targeted as a key source of potential data about these groups and organisations, their activities and characteristics. This was a very diverse sample of organisations – some with few individuals and small groups, and some that were large organisations. Sixty (60) women's rights advocacy groups/organisations were estimated to respond to the survey.

Survey Design, Administration and Exclusion

The survey was designed to gather data on broad areas which would provide a broader context for the data to be gathered through the semi-structured interview. A questionnaire of 62 questions organised in five sections was developed. The questionnaire constituted largely closed-ended questions. Key areas and questions that focused on gathering data about organisational characteristics, advocacy campaigns, and aims of advocacy were developed. Questions were to solicit data for contextual, descriptive, and attitudinal data.

The descriptive/contextual data would be useful in describing the Ghanaian context and types of NGOs involved in this advocacy. The attitudinal data would be relevant to the key aims of advocacy. The questionnaire would collect data on the number of advocacy projects in reproductive health and violence against women which the advocacy groups had implemented in the past decade and a half, the aims of the projects, which organisation(s) funded the advocacy activities, characteristics of leadership, and the budgets of their activities. Questions on the triggers of the advocacy activities, how the groups set agenda, and possible solutions they offer were also asked. Again, questions were asked about coalition building, interactions among actors, the advocacy process, advocacy tactics employed, and the outcome of the advocacy. Specifically, respondents were asked whether they work alone or if they join coalitions, which coalitions they join, the part they play in the coalition, the purpose of the coalition, the nature of membership, the size, and also the dynamics of the interaction among coalition members. Judging from the number of questionnaires, the researcher was aware that responses could not be generalised for the NGO sector in Ghana, but they would provide background information that would complement the data gathered from the interview. The questions were to elicit responses that would help situate the in-depth information from the interviews in a broader context. These were key areas identified as contextually and politically important to understanding the area – arising from the literature review and researcher reflexivity as an insider.

There was piloting of the survey with 3 women's rights advocates to provide feedback on the appropriateness of the questions, the length of the survey and the time to finish it. The only comment that was made was on one question which had to be amended.

Data Collection Challenges

The survey in practice was abandoned as a method of data collection due to practical challenges in collecting sufficient data that could be appropriately quantified. Surveys require decent sample sizes to generate valid data because the sample size should be able to provide indicative trends and represent the population being researched. Only 29 questionnaires were received from respondents and hence the data became insignificant for the intended purpose. Since the sample size was small, the data could not be said to have validity because it could not represent the sample population.

There was clear communication with potential respondents on the need for the survey. There were follow-up emails and calls to remind prospective respondents to complete the questionnaires and return them. The questionnaires were sent in hard copy and soft copy depending on the preference of the respondents. However, despite all the efforts, the questionnaire return rate did not improve. The research hence focused

on the semi-structured interview as the method of data collection for this thesis. Most respondents were to be interviewed anyway. The reasons for the disinterest in the questionnaire could be that the responses were expected in large part from the same people granting the interviews. Those who granted the interview may not have seen the need to fill in the questionnaire and grant the interview at the same time. Again, the questionnaire had 62 questions. The length may have been a disincentive to some respondents. The research hence focused on the semi-structured interviews as the method of data collection.

Semi-structured interviews are valuable in sexual and reproductive health research. They help by creating a situation whereby there is a normal conversation and participants are likely to be open about more personal issues. Semi-structured interviews enable participants' cultural values, beliefs and norms to be explored by a researcher (Mason, 2002). Furthermore, the importance of in-depth interviews is that they solicit the opinion of the interviewee on a range of pre-determined issues and offer both the interviewer and the interviewee the opportunity to add or clarify any ambiguity that might arise during the interview.

4.3.1 Interview Sample and Inclusion criteria

In qualitative research methods, researchers seek to recruit participants with knowledge on the research topic, represent the organisations being researched, and can throw light on “meaningful experience” (King and Horrocks, 2010, p. 29). Purposive sampling was used for the selection of participants. According to Clark and Foster, (2019), purposive sampling involves selecting people who ‘best fit’ the requirements of the study, according to predefined characteristics. In purposive sampling, samples are chosen based on some aspect of the knowledge of the researcher of a population, its subgroups, and the purpose of the study.

Key Participants

The key participants of this research were leaders of women's rights advocacy groups, leaders of relevant government agencies, and politicians whose agencies the women's rights advocacy groups have engaged in advocacy. They also included representatives of relevant development partners/UN bodies. The initial plan was to interview 15 selected Heads of advocacy groups, 15 Policy-makers, and 5 representatives of development partners (UNFPA, UNAIDS, DFID, UNWOMEN, and USAID). However, 16 leaders of women's rights advocacy groups, 6 policy-makers, and 3 UN representatives were interviewed. The organisations represented by the 16 leaders of women’s rights advocacy groups, were made up of 1 organisation that operated in the Greater Accra region only, 1 organisation that operated in the Central region only, 11 organisations that operated at the national level and 3 organisations that have international presence. Though the numbers needed for policy-makers and UN representatives were not achieved, the

literature supports the numbers achieved. Mears (2009) suggests that if the interviewer wishes to achieve depth rather than breadth, six to nine interviewees are perhaps enough. The leaders of the women's rights advocacy groups were the key informants about their actions, experience, and backgrounds. They shared the experiences of their organisations as well. In their responses, the experiences of other organisations and agencies got shared as part of a coalition they worked with or organisations they met in consultative meetings. To validate and add up to the responses, participants shared documents and reports on the advocacy actions they undertook. The reports they shared were publicly available and some were already on their website. The leaders of the women's rights advocacy groups had either been employed or were part founders of their groups.

Gaining Access to Participants and Organisations

Though the Registrar General's Department is where all companies register and hence could provide the list of all NGOs, the possibility of most registered companies not being active was high. Letters were therefore sent to the Heads of the Ghana Health Service, the Ministry for Gender, Children and Social Protection, and the Ghana AIDS Commission, to ask for lists of women's rights advocacy groups that they work with. The three sources named are governmental agencies that handle policy issues, supervise the implementation, and monitor Sexual and Reproductive Health and Rights, HIV, and women's rights activities in the country. They also receive reports of projects even if they did not fund them. Their database, therefore, contains active organisations that implement projects/programmes. An email was also sent to NETRIGHT, a network of women's rights organisations in Ghana, for the list of its members. Most of these lists were already available to the public through their website but request was still deemed necessary to ensure it was the complete updated list.

The Ghana AIDS Commission replied to the letter by directing the researcher to SWAA Ghana, the umbrella women-led organisation they work with for the list of women groups. The list from NETRIGHT included women's groups who do not work in the area of violence against women or reproductive health. The websites of all the members of NETRIGHT were therefore visited and groups whose work included violence against women or women's reproductive health, or both were then included in the research. It is from these lists (from SWAA Ghana and NETRIGHT) that 16 women advocacy groups/organisations were selected.

Some of the participants of this research are elites and therefore accessibility was a challenge. Interviewing elites can be challenging because they have power and also have very heavy schedules (Liu, 2018). Elites are difficult to reach because they are busy people. They usually would like to protect themselves from

intrusion and criticism and also their jobs (positions) change often and this presents research continuity and access challenges. The awareness of the above challenges enabled the consideration of a lot of time to negotiate access. Emails that emphasised the value of the participant's experience to the research were sent to participants. An Information sheet (Appendix 1) was attached to the letter to help participants make their decisions. The emails were sent early (about two months) before the intended dates for the interviews. This was to allow participants enough time to adjust their diaries and make time for the interview. Participants were also allowed to suggest dates they were available in case the suggested date by the researcher was not favourable to them.

4.3.2 Design of Semi-Structured Interview Guides

Two different interview guides were designed: one for leaders of women's rights advocacy groups and another one for policy-makers and UN representatives (Appendix 2 and 3 respectively). The development of the interview guides was informed by the literature reviewed, the main research questions, and the experience of the researcher in the field. The interview guide for the policy-makers and UN representatives contained three (3) sections. The first section comprised questions about the participant, her/his work, responsibilities, and the role his/her agency play in national policy-making and the reproductive health issues they are engaged in. These questions were to make participants relax and be able to talk freely. The second section asked questions about reproductive health and advocacy; their understanding of advocacy, the main reproductive health advocacy issues that engaged their ministries and agencies, and women's rights advocacy groups involved in addressing them. It also included questions on the effectiveness of advocacy of the groups in the policy-making/implementation process and how important the framing/presentation of the advocacy issues in the policy-making process is and their opinion on what makes an effective women's rights approach. The third section asked questions about violence against women and reproductive health advocacy: the ministry's/agency's consideration of the link between Sexual Reproductive Health and Rights and violence against women in Ghana, the policy actors they work with in designing and also implementing policies on these issues, and effective campaigns in the subject area they have been a part of. Policy-makers from parliament, the Population Council, the Ministry of Gender, Children and Social Protection, the Family Health division of the Ghana Health Service, and the Ghana AIDS Commission were interviewed. The UN workers were from UNFPA and the UNAIDS.

The semi-structured interviews with leaders of women's rights advocacy groups had five sections. The first section asked questions about the interviewees, what motivates them, and their advocacy experiences. The second section focused on the link between violence against women and women's reproductive health and

more importantly, how advocates have positioned this link in reproductive health advocacy. The third section asked questions about the nature and influence of advocacy groups in Ghana and how they research alternatives and promote specific ones. Questions were also asked about framing and its effect on the policy-making process. Section four had questions on the dynamics and interaction between advocacy groups while the last section focused on strategies used in the advocacy process. These questions, therefore, explored data around the following themes: triggers of the advocacy action, agenda-setting, and framing of issues, coalition building, strategies employed during the advocacy processes, tactics employed, dynamics of interaction with other policy actors, and outcomes of the advocacy actions. In addition, the interviews provided views as to what led to the outcome and how that outcome would be sustained.

4.3.3 Interview Schedule

The interview started with questions about the interviewees and their organisations; their motivation for the work they do and their advocacy experiences. These questions made participants relax and feel free to talk. As participants talked, they were prompted and asked for clarification when necessary. Though the interview guide was there, it was not read throughout. It was referred to when the interview was moving from one major thematic area to the other or when participants' responses digressed for a while.

Policy-makers, heads of women's rights advocacy groups, and representatives of the UN agencies were called, and emails were sent to them about the research. Letters were written to them to formalize the discussions and also asked for appointment dates for the interviews. The letters were sent early (about two months) before the intended dates for the interviews. This was to allow the participants enough time to adjust their diaries and make time for the interview because most of them are very busy people and therefore need ample time to schedule the interview.

4.3.4 Procedure

The participant and researcher agreed on the venue and time which was mostly what was convenient for the participant for the interview. The information sheet (appendix 3) had been sent via email earlier to participants. At the meeting for the interview, the consent form was presented to the participant. He/she was informed that he/she could ask for any clarification before signing. After the signing of the consent form, the interview began. Permission to audio record, though it was on the consent form, was repeated and all participants agreed to the recording. The interview began and the tape recorder was turned on. Interviews ended usually around one hour later after all questions had been asked. Few participants showed tiredness and desire to end before the one hour, but access continued to be negotiated with exciting questions based

on their interests. During the interviews, one advocate called his colleague to join the interview and share his experiences.

The interviews were conducted in 2017 and 2018. All participants except one were based in the Greater Accra region. One was based in the Central region. Fourteen (14) out of 16 of the women's rights groups were national level and international level organisations and hence their headquarters are in Accra, the capital city of Ghana and that is where their leaders operate from. The offices of the policy-makers and the UN bodies are also located in Accra.

4.4 Reflexivity

The role of the researcher influences all aspects of qualitative research. In other words, the interaction between the researcher and the object of study is ever-present (Breuer *et al.*, 2002). The interactional and constructional nature of research becomes more evident and can be experienced during interviews in the field. This implies that the researchers' world-view, experiences, knowledge, and the links they have to their topics and participants influence the research process and outcome. It is important therefore that the researcher reflects on how his/her values, knowledge, and experiences might impact the research and demonstrates that efforts are made to ensure that he/she is open to new knowledge and ideas. Many feminist researchers have hence rejected the ideas of objectivity on the basis that those who claim to be objective are often not objective but produce social science knowledge that is biased and full of assumptions. They have therefore encouraged the involvement of the researcher in the research process who can bring personal experiences to bear on his/her study.

I needed to critically reflect on my position and recognise that as a Ghanaian woman and women's rights activist, I am a member of the community I was researching. My research questions and interest came from my "insider status". It is therefore vital to the study and my contribution to social science knowledge. The knowledge of my "insider status" as a woman from Ghana and a reproductive health advocate affected my reflections on power, gender and inequality during data collection. It also affected how I negotiated access to participants, booking of appointments, my attitude towards responses and my response to issues as well as keeping to time and focus. This agrees with feminist standpoint theories that the work of several feminist academics starts with their own lives, their initial site of analysis is the experience as women as academics and scientists.

During the research my insider status as a woman and also being from Ghana made it easy to understand the culture of which I was researching and I also had shared experiences of some of the key issues of rights discussed. However, I needed to guard against the assumption that all women have one shared experience. This knowledge enhanced the need to listen, learn and document other women's experiences. Feminists posit that gender and other power relations can play out both explicitly and implicitly in research, advantaging some groups and silencing others (Harding, 1987; 1991; Skeggs, 1999). This is not about who gets to speak only but also about who gets listened to and legitimated (Lawy, 2017). I therefore needed to reflect on assumptions and perspectives and to analyse them critically and be open to recognising the significance of other perspectives and experiences from the position of the research participants and from the position of the women whose rights they fight for. This was important because some participants were members of their groups as well. For example, the participants included HIV positive women who led advocacy on gender inequalities and HIV. One critical issue is to recognise some women are in positions of power and are more privileged than others. Social class of my research participants was varied though the majority were highly educated women. Those who were not highly educated, through their advocacy experience indicated that they had control over the issues they advocate for. It was important to ensure that their voices, their stories and perspectives were given the same attention since they may not have been able to articulate in precise and legal terms the issues of power, politics and legislation processes like for example, those with a legal background. I had to recognise that every experience counts.

The advocates however as they give account of their perspectives emphasised women's shared inequality as well. Qualitative scholars expose and critique the forms of inequality and discrimination that operate in daily life (Garoian and Gaudelius, 2008). As a women's rights activist, I needed to reflect on my own standpoint on women's inequality in Ghana. This was also very important because there are many different cultures in Ghana and the position of women in the area of reproductive health could be of varying degree according to where they come from and whether they live in urban or rural areas. I needed to make allowance for learning new things from different women's perspectives. But throughout the interviews, it was clear that there are shared inequalities affected by inadequate policies, lack of policies and gaps in policy and implementation. As women in Ghana, there are major inequalities that they face.

Adu-Ampong and Adjei Adams (2020) state that getting access to the research participants is enhanced when the researcher has connections and knowledge of the researched. I had to ensure that selecting participants was handled scientifically and that I did not end up interviewing people I already knew only or friends I could reach easily. I had to follow sampling procedure to select participants as described in section

4.3.1 of this thesis. This helped in reaching participants I may not have had easy access to and hence it broadened knowledge gathered. During the booking of appointments with participants who knew me, it was easy to get dates for the interview. With participants who did not know me personally, I reminded them of acquaintances during some advocacy activities or meetings (if any) and this paved the way for appointments.

Prior knowledge of the context and advocacy action could have led to withholding of information by participants. During interviews with some participants, it was common for some to think I should know particular issues. For example, Alberta, one of the UN workers I interviewed, in discussing her organisation's involvement in passing the Ghana AIDS Commission (GAC) Bill into law stated: "*the GAC Bill, I mean it took us a long time, you know the bill was passed in 2016. It took us a long time to get the Bill passed*". Knowing my insider status and being aware that this may lead to withholding information from me because I am expected to know, I ensured such statements would not stop me from listening to the participants further and encouraging them to share their own perspectives and to delve deep into their experiences. Other researchers have similar experience. For example, Adjei Adams and Adu-Ampong (2020), faced similar challenges when as researchers they returned to their countries to do research. Participants always referred to the fact as Ghanaians, they should know the issues they were asking about. Participants also trusted me because they knew I am an insider in the subject area and share similar passion for activism. They could freely share information and discussed advocacy actions, their experiences and challenges without feeling they would be judged (Bukamal 2022).

The 'insider status' presented challenges also which included the need to stand back and analyse how 'women's rights discourses' are strategically employed in the political process and the need to reflect on my perspective on key issues to appreciate and analyse the political and social significance of alternative perspectives. Being an insider, it was important to ensure that the interview would be guided by the questions and that it would not veer into actions and events which were not the focus of the interview. This helps in addressing criticism of reflexivity as perpetuating the voice of the researcher rather than the voice of the participants (Finlay, 2002).

Reflexivity is a very important process to be carried out throughout the research process including the data analysis - practicalities, difficulties, and methods of doing it (Mauthner and Doucet 2003). Through reflexivity, the researcher makes his/her position known and discussed. Reflexivity admits that doing social research is an interactive process engaged by the individual and subjects with emotions and opinions.

Consideration of how our beliefs and experiences might have impacted the research questions, data collection, analysis, and write-up, makes the personal explicit.

4.5 Ethical Approval

The ethical issues that arise in this research are issues of informed consent and confidentiality at the data collection stage, and confidentiality and anonymity during the data analysis stage. According to Becker *et al.* (2012) ethics in research is concerned with respect for research participants, honesty, and protection throughout the research process.

This thesis was guided by the University of Sheffield's ethical guidelines (University of Sheffield, 2019). Participants had the opportunity to discuss the implications of taking part in the research. All were given information on the research: aims and objectives, the purpose of the research and their consent explicitly sought by their endorsement of the consent form. The information sheet and the consent form made it clear that participation in the research was voluntary and that if the participant decided to withdraw from the research, he/she was at liberty to do so at any stage of the research. He/she could also ask questions about the research, decline to answer questions if not comfortable and could also ask for an audio recording to pause. Participants were also informed on the use of the data: for the publication of the thesis and possible publications in journals and articles. Most participants are of high levels of education and career exposure and hence could make informed decisions. Consent permeates all aspects of the research. All participants signed the consent forms before the interview started. Consent was therefore informed and voluntary (Israel and Hay, 2006).

The guidelines require the participants of the research to be provided with an information sheet that contains information on the research including aims and objectives, research approach, and data gathering. An information sheet was thus sent to participants ahead of the interview. The information sheet outlined the advantages of participating in the research. No potential disadvantage was foreseen because participants were ensured confidentiality and that data would also be kept secure.

Anonymity throughout the research and its possible subsequent publications was also assured. To adhere to the research ethics demands, all participants' names were pseudonyms and names of groups and agencies were paraphrased instead of mentioning the actual. General descriptions of the offices of policy-makers and UN officials are used to refer to their responses instead of the exact names of their offices. All recordings and equipment used were kept under lock and key and transcriptions were kept secure. Electronic copies

were kept in password-protected files. Soft copies on the computer were secured by passwords. For the safety of both researcher and participants during the data gathering stage, all interviews were done in public places which were agreed upon during the access negotiation stage before the day of the interview and this was usually the participants' choice. The venue and time were agreed upon and largely they were the choices of participants.

Ethics is an important aspect of research integrity and must be pursued throughout the research process: data gathering, analysis, and publication. The ethics application process makes the researcher conscious of the need to reduce harm (if applicable) and ensure the protection of participants and even the researcher throughout the research process. The information sheet is attached to the thesis (appendix 1) and the consent form is attached as appendix 4.

Names of organisations and persons were not linked to questionnaires or their responses to interviews in the analysis. This was to ensure confidentiality and anonymity. Interviews were documented or recorded.

4.6 Data analysis

4.6.1 Data Transcription and Analysis

According to Brikmann and Kyale (2018) transcription involves the sampling of which of the multiple dimensions of oral interview conversations are to be selected for written transcription and which style is chosen by the researcher depending on the purpose of the transcription. I did all the transcription myself. This decision was taken so that I get to know my data more. The purpose was to report the subjects' accounts in a readable public note. For this reason, repetitions and sighs were not transcribed. After the collection and transcribing of data, all transcriptions were thoroughly read through. All data were then coded in Nvivo. The decision to use Nvivo was a huge one considering that I had not used software for qualitative data analysis before. However, the benefits of having electronic coding which makes it easy to organise data and also retrieve data encouraged me to use Nvivo. Churchill and Sanders (2007) state that though data analysis starts when data gathering begins, data analysis refers to a more systematic and concentrated stage of analysis with the view to generate paths for further data collection on the research findings. King and Horrocks (2010) assert that themes are deduced from distinctive features of the accounts, perceptions, and experiences of participants that occur frequently during the interview. This assertion is right, but themes could also be deduced from existing literature in the subject area of the research. In this research, the themes for analysis conform to major blocks of the interview guide developed and those deduced from theories: roles of women's rights advocacy groups, agenda-setting/framing of issues, tactics/strategies of advocacy groups, coalition building, budget, and funding. Attention was also paid to emerging themes between units

and categories. The relationship between these categories has been established in the analysis to produce a succinct data outcome that shows clear findings. The reliability of information was checked through a comparison of experiences and knowledge shared for similarities and differences in responses.

4.6.2 Memo Writing

Thematic memos were a way of writing down ideas and thoughts that came to mind during data gathering and analysis. This was a continual process throughout the research process. Charmaz (2006) states that memo-writing is a way for the researcher to analyse his or her ideas about codes and categories, making it possible to see some of the effects the researcher has on the data. It was also useful in filling gaps during transcription.

4.7 Conclusion

This chapter has stated the overall aim and objectives of this research. The chapter has outlined the epistemological standpoints and the research design to achieve this aim. The reasons behind the choice of qualitative research and using semi-structured interview guides have been discussed. Key issues on sampling, negotiating access, interviewing, data analysis, ethics approval and reflexivity have all been well presented. The thesis examines the role of advocacy groups in reproductive health policy formulation and implementation in Ghana, and the link between violence against women and women's reproductive health from the perspective of women's rights advocacy groups and other policy actors. It explores the policy-making process by identifying the key issues, roles strategies, actors, and the power dynamics at play during the process. The next chapter begins the three (3) data analysis chapters. It discusses the perspectives and construction of advocacy goals and foci by women's rights advocacy groups.

CHAPTER 5: PERSPECTIVES AND CONSTRUCTION OF ADVOCACY GOALS BY WOMEN'S RIGHTS ADVOCACY GROUPS

5.0 Introduction

As the first of three qualitative data findings chapters, the analysis chapters present the thematic analysis of the twenty-five (25) qualitative in-depth interviews; sixteen (16) women's rights advocates, three (3) UN workers, and six (6) policy-makers. The focus of the first chapter of the findings is to present evidence of how the participants constructed their role in the reproductive health policy-making process in Ghana and how violence against women, a determinant of women's reproductive health, is linked to reproductive health in the advocacy process. The analysis presented in this chapter focuses on how the participants understood and constructed their role as advocates and what interventions in the policy process and society were central to these. The chapter therefore answers the research question on how the women's rights advocacy groups construct and frame the problems of inadequate reproductive health rights and services and violence against women; and the proposed/preferable policy changes and alternatives. It also answers the question on how the women's rights advocacy groups conceptualise the relationship between violence against women and women's reproductive health and rights.

Utilising theories and concepts about multi-level governance and the stages of the policy process, the chapter examines the meaning of advocacy as achieving policy and social change. It also offers the analysis of the construction of advocacy goals of promoting change and monitoring resource allocation at the levels of the state. Again, advocacy is constructed as promoting societal actions and policies for women's rights. In addition, the chapter offers insights into the levels and stages in the policy process the advocates highlighted as foci for their actions and campaigns. Employing the policy entrepreneurship concept of the agenda-setting theory of Kingdon, as reviewed in chapter 3, this chapter examines how the advocacy groups act as entrepreneurs as they pursue advocacy goals on reproductive health and rights policy-making and how violence against women affects reproductive health. The chapter discusses how as entrepreneurs, they ensure that their proposed policies and laws become a reality and that the lives of their target groups and communities are improved through the policy change. Important in this chapter is also the relationship between the women's rights advocates and other policy actors and how policy actors adjust to their roles in the advocacy process. Employing the participants' description and interaction of the agenda-setting theories and also the concept of the policy subsystems and shared beliefs in the Advocacy Coalition

Framework, reviewed in chapter 3, this chapter also analyses how state agencies and policy actors engage with the women's rights advocacy groups whose beliefs they share, and how this relationship affects the advocacy outcomes.

The discussion on the meaning of advocacy for the women's rights advocacy groups, and discussion on the reproductive health issues around which the women's rights advocacy groups work are analysed from the standpoint of the feminist theory of gender inequality on the domestic level, the community level and the national level. The discussions demonstrate how the subordination of women which exhibits itself through gender-based violence, low socio-economic standards of women and their inadequate access to education and hence information, affect their access to good reproductive health. The contribution of harmful traditional practices which excludes women from decision-making, practices like child marriage and various cultural practices that expose women to casual and non-consensual sex are also discussed. There is also the argument on the responsibility of government in the provision of health services and commodities because health is a social good and how the international bodies also impact the role government plays in the process. Drawing from the themes of women and access to work, women and access to education, and women's ownership of their bodies, the chapter skilfully discusses the role of the women's rights advocacy groups in reproductive health policy-making and implementation as they perceive them.

5.1 Advocacy as Achieving Policy and Social Change

According to Joachim (2003), a critical issue that helps to explain the actions of advocates and their role in the policy process is how they understand and construct meanings including 'advocacy' as a political and social practice. Studies and theories have argued that these constructions shape the actions, goals, and strategies of advocates (Joachim, 2003). An important aspect of the interviewing was therefore to find out how advocates understood advocacy and these constructions figured highly in the data analysis.

From the data provided, one of the three main constructions of advocacy is to pursue policy and legislative change. Emma, a women's rights advocate and a journalist who is the Executive Director of a women's group and involved in advocacy, gave the account below:

“We need to use the law to influence policy and to influence legislation. So, we do a lot of research looking at some of the gaps in some of the laws.”

Emma's account provides two dimensions of change, policy change, and change in legislation. According to her, change in legislation is necessary to give legal backing to policies and ensure that there are enforcement provisions to protect women. From Emma's account, change is proposed based on gaps

identified in existing laws. According to Emma, when existing laws are not adequate, advocacy helps in influencing the change needed to fill in the gaps. Analysis of gaps, therefore, is part of the problem-framing process. It allows the conceptualization of the problem and its framing for agenda-setting. Recommendations become the proposals of alternatives for the government agenda. When alternatives are considered, selected solutions are formulated by public policy actors. Aseda, a women's rights advocate who is part of a big membership organisation, also shared her views that advocacy "*is a process to get policy-makers and duty bearers (those who must take action) to effect changes*". Having reviewed the data above, 'process' is a key concept in the meaning of advocacy as Aseda's extract states. More than 14 out of the 16 heads of advocacy groups used the concept throughout the interviews. This corresponds to the policy process as not a one-off event but a series of events that happen in parallel as policy actors seek opportunities to set the agenda.

The word 'influence' is also key in the definitions given. 'Influence' implies that there is an existing political system and advocates work as a part of the political system. Dzifa (a policy-maker), and Augusta (a UN worker whose organisation provides technical and financial resources in the area of reproductive health and gender issues campaign) provided the accounts below:

Dzifa: We target the audience because we want to see a change, so we do the advocacy to see a change.

Augusta: Advocacy is the means of influencing change to improve the lives of people. That is my understanding.

Policy-making organisations like Dzifa's own also do advocacy. The evidence available also indicate that policy-makers switch roles sometimes and get involved in advocacy. Mabel and Yawa, both policy-makers also asserted that they do advocacy. This is discussed on pages 97 and 103 respectively. This suggests that there is a degree of connection between policy-makers, other policy actors, and women's rights advocacy groups in the policy-making process and the level of connections influences the level of power. This is possible because advocacy happens at various levels and with different actors. In Dzifa's account, targeting is emphasised as important in achieving the change that is required. Advocacy needs to be directed toward the right audience for the needed change to happen. Using the term 'audience' however, explicitly shows that policy-makers are not the only target of advocacy but there is a range of policy actors that are considered. In this regard, Aseda's account also introduced duty bearers as a target audience for advocacy. Sandra, a sociologist and a women's rights advocate whose organisation works in the area of reproductive health and gender, responded to a question on actors her organisation engaged. She stated that

duty bearers include government and facility-level staff, *for access to the health service, we target duty bearers which include government workers at the facility level.* The extract shows that duty bearers refer to workers at the facility or community level. Sandra again elaborated on working with policy actors and stated that she engages:

duty bearers, government officials, service providers, and traditional rulers. Because the moment they realise that they are accountable for whatever happens, they sit up.

Also a women's rights advocate who worked extensively on universal health rights, mentioned duty bearers in a discussion on the role of communities:

I think that is something I want communities to be demanding. They should take action as a community and constantly hold duty bearers to account. (Idris)

Duty bearers are important actors because their actions and inactions also constitute policies at the community and facility level where implementation is carried out. Their discretion in the implementation process has an impact on the success of the policy implementation (Pressman and Wildavsky, 1984; Matland, 1995). The recognition of this informs strong engagement of duty bearers in the policy-making process, a bottom-up approach that engages duty bearers and grassroots actors to effect policy change. One of the policy-makers stated:

Advocacy is to capture the attention of various spheres of society on issues of HIV, to engage from the highest level of government through to the grassroots. (Mabel)

From Mabel's quote above and the quotes from Idris, Sandra, and Dzifa, it is evident that advocacy targets various spheres of society to achieve change.

A second major way of constructing advocacy expressed by three participants, Mabel, Aseda and Godfred (Godfred is a male and a women's rights advocate with a political science background), were "*talking on behalf of people.*" According to them, advocacy is to give the voiceless a voice. From the data below, the women's rights advocates perceive that they become the voice of their target beneficiaries. To illustrate this claim, we can consider how these participants emphasised these aspects of advocacy. Aseda provided "*speaking for those at the lower level to make sure that we task those who are supposed to act.*" Mabel corroborated Aseda's position and explained that advocacy is when "*key advocates or key people who willbe the mouthpieces on HIV issues for prevention.*" Godfred also stated that:

We perceive advocacy as a process to achieve a particular goal, not necessarily on our behalf, but on behalf of the vulnerable people, those who don't have voices. Those who are down there, if I say down there, below a certain level of society that we need to bring them up so that they will be able to get results or get benefit from society. (Godfred)

This position of the three participants is informed by the view that the people affected by reproductive health issues or gender-based violence may not have access to policy-makers to make their demands or they may not have the power to be heard by policy-makers and duty bearers. They suggest that advocacy ensures that someone who has the voice or whose voice can be heard represents the target beneficiaries. This links to the debate about representation. The above standpoint places the affected people as vulnerable and without a voice and hence should be represented. Below is an extract from Grace, the Executive Director of her organisation and a Gender expert.

Grace: I decided that going into the NGO sector will help me add my voice, to be a non-state actor to say what I have to say especially, if I have the evidence for voiceless people, people whose voices are not heard anywhere, they are suffering quietly but nobody spoke for them.

Alleviation of the suffering of the voiceless and less vulnerable and ensuring their access to services as a right is mentioned as the overarching motivation for advocacy. According to the advocates themselves, advocacy leads to improvements in the quality of life and health of their target beneficiaries. However, Yawa, one of the participants, who is a legislator, thought that the notion of *'talking for'* is wrong, and that *'we advocate with and not for'*. Yawa, explained that in advocacy, groups or individuals:

work with the people to raise their concerns and address them. It is a process of codifying the issues people raise as their needs for policy-makers attention and hence the affected communities themselves are involved. (Yawa)

Advocates therefore guide the process. With that understanding, the issue of vulnerability is limited, and certain voices are given to the people affected. They become participants of the advocacy and not mere receivers of benefits. This makes people and communities empowered to be supported to act on issues that affect their lives. These different perspectives resonate with the debates about how to pursue advocacy in partnership with the affected (Kirby P. et al. 2008). Such as we can see these debates shape constructions of practice and goals of advocacy in Ghana.

Thirdly, advocacy was constructed as concerned with resource mobilisation to implement reproductive health and gender-based violence reduction programmes for the improvement of the lives of people. In the extract below, Mary, a UN worker, when she was discussing what advocacy means, provided the data below:

Advocacy is getting policy-makers to put their resources where their mouth is. There is too much talk without action. Advocacy is getting policy-makers to put resources where the issues are much more urgent. In our part of the world, politicians will always want to invest in infrastructure that can win them power so they won't use scanty resources to work on non-tangible things (policies that cannot be seen) like gender issues. So it needs a lot of advocacy to let them know that they need to invest in gender issues for long-term benefit. (Mary)

According to participants, there are many promises from the government but the implementation of what they promise becomes the problem. According to Mary, one of the key factors of lack of implementation or inadequate implementation of policies and laws is inadequate funding. In this case, advocacy is to ensure that government or policy-makers go beyond rhetoric and commit funding to implement existing policies and laws. Advocacy is also to ensure accountability for policy, going beyond election-appealing statements to pushing for long-term policies. Mabel asserts that advocacy includes getting key people to be the mouthpiece “...for financing, for capacity building and resource mobilisation...” It was the view of 7 participants in this study that in a developing country like Ghana, the government does not sufficiently invest in reproductive health. This provides a strong premise for advocacy on the government to increase resources for reproductive health and related programmes. The excerpt from Mary also indicates gender-informed framing of the goals of their advocacy. Mary suggests that policy-makers prefer to invest in infrastructure which can easily be seen than invest in women’s issues including health and violence against women which are ‘not physically seen like buildings and vehicles’. Hence, according to Mary, advocacy is to ensure that policy-makers invest in these also for the long-term benefits of society. Gender advocacy, therefore, seeks to press the government to prioritise gender issues also. This position of Mary is also elaborated by Emma as she discusses making policies more gender-sensitive and engendering legislation.

So basically, we look at how to make policies more gender-sensitive or engendering policy, engendering legislation. And when it comes to reproductive health rights, we also did some work with Bill and Belinda Gates foundation, and we were considering harmonising the laws that promote women’s reproductive health rights. (Emma)

Advocacy, according to Mary and Emma should have a gender emphasis to ensure that policies, legislation on reproductive health programming, and resource mobilization target the needs of women.

This section has argued that there are three constructions of advocacy in the data; seeking policy change, representing the voiceless and the vulnerable, and ensuring resources are allocated for gender policies and their implementation. In discussing these, a wide range of policy actors were considered, especially duty bearers. The participants of this study seem to be pointing to the significance of street-level bureaucrats as agents of change (Lipsky 1980). They are very important in the successful implementation of policies at the community and facility levels and their actions or inactions affect access to services. Problems are framed to have gender sensitivity. The problem identification and framing include identifying gaps in existing policies and engendering such policies. The discussion demonstrates the concurrent framing of problems

and consideration of issues of implementation, pointing to the significance of Kingdon's (2011) policy streams running parallel in the policy-making process.

5.2 Constructions of Advocacy Goals and Foci

The three broad constructions of advocacy of achieving policy change and social change, government accountability, and the mobilisation of state resources, all are orientated toward the benefit of disadvantaged and less powerful groups in society. The qualitative evidence generated in this study then established how advocates constructed their actions and roles in terms of having an impact on all stages and levels of the policy process. It is analytically interesting how advocates are creative and strategic in their campaigning and may pursue both implicit goals (e.g. women's rights and feminist agendas) and explicit goals to achieve policy change and the right implementation of policies in this context.

5.2.1 The Issues around which Advocacy Actions are Constructed

According to the participants of this study, women in Ghana experience human rights abuses that affect their access to reproductive health care and, in some extreme cases, their lives. Murder, rape, battering, sexual assaults, violence against women in the health facility, economic violence, denial of free movement, psychological abuse, and related effects on women's reproductive health are the major issues that these advocates pursue. They also advocate for government accountability and mobilisation of state resources to improve the implementation of government reproductive health services and allied policies that enhance the health of women. Many of the participants also advocate on HIV and access to treatment, immunisation, adolescent reproductive health especially teenage pregnancies and its negative effects on the health and education of girls, access to safe abortion and family planning.

The extract below from Emma, the women's rights advocate who talked about engendering policy in the advocacy process explained how she joined her organisation. She elaborated that there was serial murder of women in that period in Ghana and hence she was invited to join her organisation to support the advocacy process which was demanding the government to bring perpetrators to book and protect women's lives.

I started working with my organisation when young women were being murdered around the time of the Rawlings regime and I was asked to provide media coverage of the advocacy actions of a coalition of women's groups called the Sisters' Keepers. The coalition was mainly advocating against these killings and to get the Police response because they were not arresting any murderer and we were seeing more and more women being killed all the time. (Emma)

According to the extract from Emma, the inability of the Police to arrest the killers were inactions of the government and this necessitated the advocacy by the Sisters' Keepers to pressure the government to ensure

women were secure and that justice was served. Women's groups realised that as the gender experienced the menace, they needed to raise the issues that affect them and seek justice. Apart from the murder of women, participants also discussed sexual abuse. Harriet, a lawyer, and women's rights advocate in a research organisation, highlighted the sexual abuse of girls in schools and in the communities and explained:

Teachers and students are all perpetrators of sexual violence against women. So the issue of violence when in school and also in the communities is critical. (Harriet)

The data from participants indicated that the inactions were not only at the level of government, but the communities were also not safe spaces for girls and young women. Sandra, a women's rights advocate who works on violence and women's reproductive health, explained this when she discussed rape when she was answering a question on the types of violence against women which affect women's reproductive health:

Rape and this is where our sociocultural norms show their bias. I don't know whether you listened to JOY FM yesterday, a four-year-old girl has been raped by a fetish priest. The police are sitting down, the traditional leaders are saying the accused who is a fetish priest said he is not the one. The Domestic Violence and Victims Support Unit of the Ghana Police Service (DOVVSU) did not follow up. The question is; has the girl received any rehab, medical, or social support? These are the issues. People don't talk about them. Go to homes, men are raping their wives and husbands will say 'how can you say I raped my wife?' (Sandra)

In the extract above, Sandra states that societal norms and traditions that encourage the subordination of women and regard women as not agencies of their own, prevent access to justice when sexually abused. Sandra reiterates the lack of action by both the government and traditional/community leaders to protect women and girls. According to Sandra, this is influenced by the socio-cultural norms that take negotiation for sex outside the domain of women. This power imbalance is rooted in the culture (Tenkorang *et al.*, 2013; Akumatey and Darkwa, 2009). Sandra elaborates on the abuse of women and girls by fetish priests and the covering of such crimes by the leaders of the communities. Key advocacy issues raised about seeking redress include rehab, psychological support, and medical and social support. Social support could be in the form of encouragement to report and ensure that the perpetrator has been handed over to the law. One of the controversial areas of sex abuse raised by Sandra is marital rape. Ama, an academic and a women's rights advocate whose organisation works on sexual reproductive health and rights, provided insight into the sexual abuse in families in the quote below:

In the papers, we read that a man went home and he wanted sex. His wife did not want it, then he got annoyed and forced her... (Ama)

Another women's rights advocate who works in the area of reproductive health, stated that:

Almost every woman has gone through some sort of abuse, even if you are in a stable marriage, the man still has all the power and so you see women go through this. You talk about it, but they will not listen because society is for men. (Grace)

From the perspectives of the participants of this study, therefore, women experience abuse but because of patriarchal relations, they are not able to seek redress. The use of the word 'wife' suggests a move of such crimes from public discourse and presents them as exclusively domestic concerns (Joachim, 2007). These inequalities also affect women's reproductive health (Akumatey and Darkwa, 2009). The marriage institution is therefore gendered and provides a weak political standpoint for women (Acker, 2015; Britwum and Cusack, 2009). Sandra's quote also raises issues on the knowledge of women on legislation and their seeking of justice behaviour. It is critical to consider how women position themselves in the face of the law when abused.

According to the participants of this study, the socio-economic conditions of the country have the potential to influence violence against women by men and put women in a vulnerable state for abuse. Sandra shared this perspective while explaining that the harsh economic situation in the country put men under stress and they in turn vent their anger on women. The quote below from her evidence of the above standpoint:

Because of the economy, some men are stressed out, and some men have lost their jobs. Just look at it, Capital Bank was closed down and top management members of Standard Chartered Bank were laid off. They go home stressed, and they vent their stress on their women. Women are raped, they are battered and at the end of the day, it affects their reproductive health. (Sandra)

Though the above analysis by Sandra seems plausible and there is evidence that the economic issues fuel misunderstanding between partners, a critical question could be why women are not abusing their men since they also operate in the same economy and experience the stress that men experience? The quote below from Felicia as she discussed the challenges faced by women living with HIV reflects on the importance of women's work and the role of the family's economy on violence.

Many were going through violence, verbal violence, so we encouraged them to go through income generation activities. We realised that when a woman is not working, she becomes a burden on her partner. African partner, if you can do something, not asking him every day for money, then he respects you. (Felicia)

As reviewed in the literature, the traditional role of men as economic/financial providers to the family is an underlying factor (Britwum and Cusack, 2009). With the rise in women's educational level and their increased participation in the workforce, it is expected that they are contributing to the finances of the home. Therefore, other factors account for men's violent behaviour (Britwum and Cusack, 2009).

Two participants discussed another form of violence against women, which they termed ‘violence in the health facilities’. According to Godfred and Idris, pregnant women experience violence (verbal abuse, extortion, undue delays of service) from some health workers when they visit the health facility. Idris expressed this concern when he stated:

now there is another form of violence that I want to talk about and that is also an issue, violence against women by healthcare providers.

Idris gave an example of how a nurse used to verbally abuse pregnant women and extort money from them so women from 10 communities that the facility served stopped accessing health services and were giving birth at home. Godfred also provided data that “*you know nurses sometimes talk to patients in a way that dispels them from the hospitals.*” This verbal abuse and extortion is institutional-based violence that affects the ante-natal and post-natal health-seeking behaviours of women. Godfred discussed how advocates work to ensure duty bearers pay attention to these issues.

We went out to advocate with the hospital staff, engaging the health facilities to understand that their attitudes to the needs of those accessing the facilities affect their access. They needed to understand that the rights of patients should be upheld. We women need to come to the facility. It should be a friendly environment. So, at any point in time, the person is ready to come and even lead others. (Godfred)

Six participants also indicated that they have done a lot of work on reproductive health. All of them advocate on issues around HIV and access to treatment. Whilst Linda works solely on HIV and gender-based violence, Grace’s organisation, in addition to HIV, advocates for child immunisation, Ama’s organisation works on teenage pregnancies, as others also work on safe abortion services and enhancing access to reproductive health services. In the quote below Akosua discussed her organisation’s work on family planning and fistula. Akosua’s quote highlights the gender dimensions of fistula where women become societal outcast because they are in that health condition.

We have done a lot on reproductive health. We have worked to ensure that women make informed reproductive health decisions, when it comes to family planning and childbearing issues. We also helped women in the Northern part of the country who suffered from fistula but they did not have adequate knowledge on it. The society in that part of the country saw it as a curse, so they were being seen as outcasts or cursed women. So, with the help of the organisations, we were able to advocate in the communities that fistula is not a curse.

The advocacy was to ensure that communities know about the health condition and disabuse the minds of people on myths and superstitions that fuel violence against women. She therefore raises the role of religion in gender-based violence of harmful traditional practices.

Yawa, a policy-maker, also shared an advocacy around similar harmful traditional practices coded in religion called ‘trokosi’, a female servitude system practised in some tribes in Ghana where girls are sent to shrines to be wives of the fetish priests to atone for sins of their families. She indicated that though she did the advocacy among top feminist groups, unfortunately, people did not seem much interested in the issues:

Top women feminists met at the British Council, and I raised the issue of ‘trokosi’ but no one seemed interested. So, I think health rights and gender is not on top of the agenda of these women. (Yawa)

From Yawa’s quote above, she did not get the anticipated response of feminists to carry on the advocacy. Though she concludes that the women’s groups did not show interest in gender and health, this contrasts the evidence of all the other participants. The response could have been more positive if there was a sustained advocacy since she stated that she raised the issue in a meeting. As indicated by Honeycutt and Strong (2012), advocacy outcomes sometimes are achieved in the long term. Another important issue to note is the attempt of Yawa, a policy-maker, to engage in advocacy. This is found among many of the policy-makers as they sometimes switch roles.

The above discussions on Akosua and Yawa’s extracts highlighted the role of religion in women’s reproductive health and gender especially traditional African religion and beliefs. Ekem, a male reproductive health advocate involved in abortion rights, however, provided evidence that the established Judeo-Christian religion also impact negatively on reproductive health advocacy. His quote below expands the issue.

Ghanaians are peace lovers, and they are more catholic than the Pope ..., so often people use their religious values to judge others. So even people in high places say that abortion is a crime, abortion is sinful, but I have always argued, that let us assume that abortion is sinful, will you commit the sin and die or commit the sin and live, so I want to do a safe abortion and oftentimes, we have won this and that is the main challenge.

In the pursuit of safe abortion services, Ekem’s organisation faces opposition from high level religious leaders and policy-makers on the basis of abortion being sin and also a crime.

From the above analysis of data, it is evident from participants of this study that gender inequality fuelled by political inactions, and socio-cultural and religious norms produces violence against women and this negatively affects their reproductive health and access to health services. Murder of women, rape and inadequate actions of government became the problem that government action was needed to solve them, corroborating the discussion of the problem stream by Kingdon (1984). The moods this insecurity produces create a national mood that triggers advocacy for a change. The major cross-cutting themes that emerged during the data analysis included similarities and differences across participants in how they constructed

and focused the primary goals of their advocacy organisations around the issues of reproductive health and violence against women analysed above. ‘The section below will present and analyse data organised around the key areas of policy change, social change, government accountability, and the mobilisation of state resources to combat the violence and reproductive health issues discussed above. The section explores each of these goals of advocacy, the specific changes they sought to realise, and the interventions used.

5.2.2 Promotion of Culture and the Idea of Rights and Justice

A major theme emerging from the data is cultural change and the promotion of the very idea of rights and justice by women's rights advocacy groups. Women's rights advocacy groups work to raise awareness on policy issues that concern the communities they represent. Yvonne, a women’s rights advocate, constructed her advocacy around cultural change for women regarding how they understand their rights.

There was a lot of awareness-raising at the community level looking at the protection of the rights of vulnerable populations and then gradually moved on to do a little more of national-level advocacy, ...doing a lot of research in that regard and so still in the sectors of protection of human rights and women’s rights, children’s rights. (Yvonne)

However, her excerpt suggests that advocacy for awareness-raising which culminates in cultural change on how women perceive their rights and agency is usually at the community level: engaging community members on issues of vulnerabilities and protection of their rights. Another participant, a women’s rights advocate with a Human Resource background who works in HIV and reproductive health, while discussing the aims of her organisation, elaborated they:

Educate and raise awareness of the Ghanaian women, especially rural Ghanaian women, with regards to HIV and AIDS epidemic, sexual reproductive health and any related issues and empower them to make informed choices. (Akosua)

From Akosua’s perspective then, the rural Ghanaian women lack access to information and knowledge with the ease that the urban women do. Raising the awareness of rural women is considered an empowerment process for informed reproductive health choices.

By implication, Yvonne and Akosua provide insight into one of the factors of vulnerability, which is a lack of information and knowledge. They opine that some people may experience violence and have limited access to reproductive health because they do not have information on their rights. This corresponds to women’s level of education and access to information. Akosua, in the quotation below, referred to how lack of information made rural women in Northern and other parts of Ghana live with fistula and its associated pain and shame.

We also helped women in the Northern part of the country who suffered from fistula but they were not aware that it was a physical condition and could be treated. Their society saw it as a curse, so they were treated as outcasts or cursed women. (Akosua)

Akosua's extract shows that lack of knowledge coupled with religion and superstition puts women in suffering. According to Akosua and Yvonne, the availability of information and knowledge can bring a culture change and perception of rights, and this can produce cultural orientation and empower women to demand their rights and access to reproductive health. The geographical inequality makes women in rural parts of the country disadvantaged when it comes to access to information that could translate into good reproductive health of women. Asante and Zwi (2009) largely documented the regional/geographical imbalances in the health sector.

Closely related to the awareness creation is also that advocacy at the community level helps bring up issues from the grassroots to the attention of the policy-makers and thereby connecting communities to the political process.

I think one main thing is for advocacy groups to bring the bottom-up approach to policy-making, because most of the time they work in communities and are in touch with beneficiaries of services, so they should be able to bring the interest of beneficiaries up to duty bearers. This is one critical thing advocacy groups do. Most of the time, policy-making is top-down but advocacy groups bring issues from the ground and bring them up. (Yvonne)

This bottom-up approach to policy-making and connecting communities to the policy-making process provide alternatives to what otherwise, the situation would be without advocacy. Top-down policy-making processes where policy-makers decide all that should happen and force them on communities do not always meet the needs of the communities.

Emma, the women's rights advocate who joined the Sisters' Keepers when the serial killing of women was high in Ghana, reaching 30 between 1998-2000 according to CNN.com (2000), indicates that her organisation raised awareness of gender-based violence and its link to reproductive health and got community groups to identify their solutions. Her quote below expands the issue.

From 2002-2004 we did some work around advocacy and reproductive health rights. The objective was to raise awareness on the issue of gender-based violence and its link to reproductive health rights and to get the community groups to come up with their home-grown solutions as to how to deal with gender-based violence. (Emma)

It implies that communities participate in the problem identification and solutions processes and subsequently set the agenda around their needs. This means advocates do not advocate 'for' but advocate

‘with’ the communities, creating platforms together for the voices of target groups to be heard. This agrees with Yawa’s position when exploring the meaning of advocacy, that we advocate ‘with’ the affected communities but not ‘for’ them.

In discussing her involvement in this campaign, Emma further constructed advocacy in terms of promoting rights through legal changes in the extract below:

The whole exercise was to use the findings to promote women’s rights and also advocate for reproductive health rights ... The main issue was to ensure that women will take up the laws by themselves and claim the legal capacity.

For Emma, the role of advocacy action is therefore to empower women to know the law and seek redress.

5.2.3 Achieving Policy and Social Change

The advocacy organisations in this study constructed their role as orientated towards assisting and ensuring governments formulate policies that will promote human rights and enhance women’s reproductive health. The data indicates that in working on policy and social change, advocates propose new policies and laws, and propose amendments or reforms to existing policies/laws. Harriet, a lawyer, and a women’s rights advocate, when asked whether their advocacy proffer alternatives explained that usually, her organisation works towards new policies.

It is not an alternative as such.... It is not as if the government already had something, and we say this is not working. Our policy work had always been working with the government to come out with something new rather than alternatives. (Harriet)

In this regard, advocates pursue the formulation of new policies around issues that concern their target groups. She gave an example of such advocacy action her group undertook for a new policy formulation which was the passage of the Domestic Violence Law ACT 732 passed in 2007:

I can say that sometimes it is Civil Society engagement that leads to policy formulation and a typical example is the Domestic Violence Law that was driven by Civil Society. (Harriet)

Participants of this study used Civil society as another term for NGOs or to describe the structural domain NGOs operate from. Six of the advocates interviewed used the terms interchangeably. A Medical Doctor, and a women’s rights advocate who referred to her organisation as Civil Society when she talked about access to government platforms for data on HIV indicators stated:

Yes, but importantly, the platforms are accessible to civil society because I told them a lot of times, the government has data but it is not accessible to us. (Linda)

Yvonne, another advocate who works with a legal group, also referred to her organisation as Civil Society “*and what we did was to let civil society groups understand how they can do advocacy through the UN mechanism.*” Godfred, a women’s rights advocate also elaborated:

I think the condition is that we live in a free country where there is space for civil society advocacy and campaigns. We have that space to talk.

Ikem in discussing funding for his group referred to them as civil society:

There is a local organisation also known as STAR Ghana which is a kind of pull fund manager providing support to Civil Society groups in Ghana. So we get some support from them.

One of the participants who is also a reproductive health advocacy, however, broadened the use of the term Civil Society to include women when she was explaining her work towards immunisation. She stated that:

we brought Civil Society together, we got a lot of mothers to see that the resources and immunisation is their right, so we mobilised all those people as our allies then we brought in the media. (Grace)

The term Civil Society is used strategically by women's rights advocates to provide legitimacy to the action as non-governmental organisations with the interest of their target groups being their main concern. By Harriet saying the coalition reflected civil society, the interest group nature of their action is legitimised. Again, the use of Civil Society suggests advocates are taking forward societal and community concerns and are not being paid by the government for their roles, unlike policy-makers or professionals.

Harriet used the term ‘engagement’ to mean advocacy actions. Engagement is a broader term that connotes that advocacy involves many other events and actions. Engagement also connotes collaboration efforts with policy-makers. Harriet was emphatic that it was the advocacy of women's rights groups that led to the formulation and passage of the Domestic Violence law. On how civil society achieved the policy formulation, Harriet explained:

...once we did the research, we had the data then we came together. One group, the lawyers, put together a draft bill, we went to the Attorney General who is now the President, and said, look, you cannot say that there is no violence.

The Civil Society mentioned by Harriet is the Domestic Violence Coalition, which primarily comprises women's rights advocacy groups. Harriet's account shows that the advocates of the Domestic Violence Bill drafted the Bill themselves. Policy drafting usually in the policy-making process is usually the preserve of the policy-makers as advocates and other policy entrepreneurs push the draft bill for inclusion on the agenda. Advocates drafting the bill give insight into additional roles that advocates in Ghana play if they want their issues to be on the agenda and achieve policy change or have laws enacted. This suggests they understand their context and the additional roles it elicits for advocacy. Harriet's statement below elaborates this perspective:

We had the first draft in 2001 whilst the President was the Attorney General and we worked sustainably.

Drafting laws is part of the advocate's role in Ghana, and working closely with legislative-making bodies is therefore viewed as a legitimate and necessary advocacy action. As part of influencing and shaping policy agendas (the goals), advocacy groups make links with and communicate with policy agencies and hold various consultative meetings with other policy actors for effective advocacy. The drafting of the Bill also connotes that women's rights groups have diverse and extensive knowledge and skills, and they could perform roles, which traditionally, may not be advocates' roles. Mabel, the policy-maker, defined advocacy as affecting all spheres of society, discussing the role of women's groups in HIV policy-making processes:

A big case was made on the fact that women's rights advocacy groups had peculiar experiences and skills that put them in stronger advantage when it came to certain issues so there was a strong movement for specific partnerships with women's groups by government. (Mabel)

Diverse skills and peculiar experiences are needed by women's rights advocates in the policy-making process.

A second campaign that was considered in the interviews as leading to the formulation of a new policy was the Ghana AIDS Commission ACT 2016 (ACT 938). Yvonne, a women's rights advocate, discussed the activities of her organisation and other women's rights groups which led to the formulation of the Ghana AIDS Commission Act, a specific HIV Law. Her excerpt below provides insight into the campaign:

With HIV/AIDS, for instance, we did a legal audit looking at the existing human rights framework that protects the rights of People Living with HIV (PLHIV). In this legal audit, one of the major suggestions we made was that the country needed an HIV-specific law. So that is one initiative we took that helped to influence the current Ghana AIDS Commission (ACT 938) on HIV. So there is a GAC Act right now, just on HIV and key populations and it was a recommendation from the legal audit. (Yvonne)

The legal audit discussed by Yvonne means there were various policies and laws on HIV existing in different documents and under different areas of health. The policies were fragmented and hence it was difficult to assess their adequacy in meeting the needs of People Living with HIV. The audit, therefore, helped to identify provisions on HIV already existing in the various policy documents and the gaps. This was done against the knowledge of current trends and the needed legal framework to help protect the rights of people living with HIV and enhance access to HIV services. To present an informed representation of and develop proposals about legal change, Yvonne's organisation did the legal audit and based on the results, proposed a specific HIV law. This perhaps demonstrates the perceived role of advocacy organisations to provide informed policy recommendations.

Three participants presented the key role of advocacy as achieving legal change in formal rights on the basis that policy frameworks alone did not secure rights. According to the participants, advocacy groups advocate for the enactment of laws because though policies are good and they provide guidelines for the protection of rights and provision of services, they are not legally binding and, in that situation, women are not able to seek redress when they are abused or when they are not able to access reproductive health services. According to Emma and Harriet, who were involved in the Domestic Violence Bill advocacy, to make policies legally binding, the Bill must be submitted to parliament for it to be passed into law. When it becomes legally binding there are punishment and enforcement processes that support women to invoke their rights by seeking social justice. Emma, responding to a question on the Domestic Violence ACT, elaborated in the excerpt below:

It had more to do with the number of sexual violence cases that were being reported and the fact that there were no specific laws that addressed the issue of domestic violence. So, there was a need to look at amendments to the criminal law. You find issues that were covered in the laws but that did not address the issues of domestic and gender-based violence, so you would realise that because of that, the police were constrained or limited. What law are they going to use to prosecute? And then, in the same way, the person who is reporting does not find that kind of support. Because if the police can't help, then you suffer in silence. So, we needed to have a law that addressed the issue. (Emma)

Through this activity, women's rights advocates demonstrate that one way to achieve social justice and protect women is by promoting criminal justice reforms and legal changes. Mabel, a policy-maker who is also involved in advocacy corroborated the above position by Harriet and Emma and shared her perspective:

We have a judicial system that may render the survivor even more vulnerable, more abused than they had suffered from violence. We have protraction of cases in the court and at our domestic violence units. We have costs that they may not be able to afford. (Mabel)

It is evident from the above quote that advocacy for legal reforms to promote social justice is a key goal and the main actions revolve around policy recommendations to ensure that the judicial system is supportive of the justice-seeking behaviours of women.

The Women's rights advocacy groups involved in this study presented an account that indicated that it is not all advocacy for policy change that leads to the formulation of new policies. Some advocacy actions study existing policies, identify gaps and advocate for the gaps to be filled. In this regard, advocates seek to improve current policies by proposing reforms. In the quote below, Grace, a participant, gave insight into the kind of thoughts or analysis that goes into advocacy for policy reforms. According to this participant, certain deliverables need consideration before a proposal for advocacy reforms is made and these include

the perspectives and experiences of the target group a policy serves is important. According to the study participant, it is also important to engage with the community that will benefit from the policy change/reforms to discuss the proposed reforms. The participant again raised the importance of considering the purpose of the policy reforms proposed as she asserted that every policy needs to fulfill a purpose. The policy change should, in her view, advance the rights of the community. In the extract below a case is being made for such policy reforms:

If you want to change the policy you have to look at certain deliverables; the people that the policy is about, the purpose of the policy, and you have to look at the results, and what has been done already. You also need to look at the services. What is the purpose of the policy? What has changed? What are the gaps? So, we look at the gaps in policy and if we think if the policy is not achieving the purpose of which it is done, then we come and we do the analysis and identify it and we start engaging key people who matter on the policy change. (Grace)

The overall goal of such advocacy actions, therefore, was about improving current policy and provision. The participant constructed the legitimate means for achieving policy reforms as being systematic policy evaluation, policy research, engaging with policy-makers, and promoting improvements. By framing their actions in these terms, they also seek to legitimise their actions as more than mere interest-based politics. An evidence-based discourse is being constructed which provides insight into how these advocates understand being effective and persuasive in their actions. They know policy-makers need quantified and scientific evidence of a problem and they can't merely present human rights moral arguments. The evidence-based discourse is discussed in detail in the next chapter.

Three other advocacy interventions discussed by participants in the area of policy reform goals were getting family planning commodities on the national health insurance list, delivery of abortion services by middle-level health providers, and sexuality education in schools as social goods and rights respectively. According to the participants of this study, a critical issue for many advocates had been enhancing the provisions of the National Health Insurance to include reproductive health services based on the need to recognise health insurance as a social good. As stated in the literature, Asante and Zwi (2009), the National Health Insurance Scheme was introduced in 2003 as an alternative health financing to replace the cash and carry system whereby users pay fees for healthcare at the point of service to curtail the consistent drop in the number of outpatient consultations per person per year (Per capita OPD attendance) (Seddoh and Akortey Akor, 2011). Idris, a male and a women's rights advocate in the extract below provides the work done by advocates to ensure enhancing the National Health Insurance Scheme to include reproductive health services and commodities:

When the national health insurance scheme was introduced, reproductive health services were not covered. It was because of continuous advocacy of reproductive health NGOs, like Alliance for Reproductive Health and Oxfam who constantly argued and brought evidence that reproductive health should be made part of the national health insurance scheme and now it is part. (Idris)

Idris' account in a follow-up discussion to his statement, indicated that at the introduction of the National Health Insurance Scheme in Ghana in 2003, advocates studied the policy and noticed that there were gaps, especially that which concerns reproductive health services, and hence advocates demanded the gaps to be filled. The extract from Yvonne's interview below further elaborates on the importance of this advocacy goal. She indicated that it was not the whole reproductive health services that were absent in the National Health Insurance Scheme but only family planning services and commodities:

Yvonne: Then we can talk about our national health insurance. Currently, we know that there is the provision of family planning under the national health insurance scheme, and I remember in the 2012 ACT (852) of the National Health Insurance, we did some advocacy with the Planned Parenthood Association of Ghana (PPAG) a reproductive health organisation and the Alliance for Reproductive Health (a coalition of reproductive health organisations) which sought that the National Health Insurance ACT, when it was going to be amended, recognizes or covers provisions of family planning services. Currently, that is in the National Health Insurance.

In this instance, the advocates are seeking formal recognition that reproductive health is an essential healthcare service, a social good, and a social right. Therefore, the national health service should provide access to health. According to Yvonne, the argument put forward during the advocacy for the inclusion of family planning in the NHIS was that when women were going to give birth, they had free maternal services. However, the National Health Insurance did not make provisions for family planning services and commodities (contraceptives) to support those who would like to prevent pregnancies. Women who choose to prevent pregnancy as an option should have access to family planning commodities and services as their right. This advocacy sought to have amendments to an already existing policy. It highlights the importance of health financing to women's rights advocates and the need to ensure that commodities that are needed to enhance women's choices regarding their sexual and reproductive health are included because they are social goods.

Another related advocacy in the reproductive health policy review discussed by some of the participants was the delivery of family planning services and abortions. A key concern for participants in this study was that only doctors were allowed by policy to provide family planning and abortion services. The extract below is from Ikem, a male, a Doctor and a women's rights advocate:

Ikem: Over the past years, we had several advocacy actions. One was to allow midwives, middle-level providers, to provide services. It was a strong battle. We went as far as the nurses and the

Midwifery Council. The Director of the Ghana Health Service was involved. A lot of people were involved. We demonstrated that the midwives when trained could provide services. That was the first advocacy. With that, we even changed the curriculum of training of midwives, printed and paid for it ourselves, so that midwives can have the initial pre-service training before they come out of school.

The above advocacy activity led to amendments in policy and training manuals for midwives so they could provide services. Here also there is a major focus on establishing family planning as a social right and a social good. It is important to note that the advocates (the lead advocate being a medical doctor) targeted the Midwifery Council and the Director-General of the Ghana Health Service to seek to amend the training manuals of the midwives as they advocate reforms in the service policy. The advocates had to invest money in revising the training manuals of midwives and paid for printing themselves. In this regard, advocates are advancing women's rights by developing and influencing professional standards and training, and making services more comprehensive, of higher quality, and accessible. When middle-level professionals are allowed to provide family planning services it implies that a greater number of facilities in the country could provide these services.

Ikem stated that the advocacy was a strong battle. This statement is important in the discussion of advocacy as it highlights the role of power in the policy action continuum. The qualitative data in this study indicate that seeking change from existing policies is not achieved easily. This is because the change being asked for may challenge existing norms, interests, and behaviours of policy-makers and duty bearers and place a demand on them. According to Ikem, who presented himself as a reproductive health advocate, sexuality education policy in schools had focused on abstinence to the detriment of young people. Ikem, in the quote below, presented the view that improved sexuality education in schools is needed to enhance adolescent reproductive health and rights:

Ghana Education Service and Ghana Health Service have maintained an abstinence policy as a way of making sure that our children do not become pregnant. This has been the policy. But evidence from many other countries, including African countries, shows that this policy, even in our own country, is not working because we still have a lot of our children becoming pregnant before they become adults. So, we have tried to advocate this comprehensive sexuality education to let the children know so they can make informed choices. (Ikem)

The above advocacy sought reforms in the education policy of basic and second cycle institutions (the first 12 years of formal education) by making sexuality education prominent in the curricula of schools. According to this participant, this would reduce teenage pregnancies among school children. Ikem added the following:

We call it age-appropriate comprehensive sexuality education. We believe that every child must know about the human anatomy, and functions of the human body parts so that they will be able to prevent or delay sex. Oftentimes we hear children in schools get pregnant just because they don't know how to prevent pregnancies. So strong advocacy went to the Ghana Education service which didn't want to include sex as part of the curriculum for the training of children.

In this advocacy, women's rights advocacy groups sought to promote reforming the education curriculum and challenging the prevailing culture. They also worked towards mobilising educational professionals to strengthen the action. The goal was to promote children's rights to sex education via educational reforms in partnership with professionals. They were also to generate political, cultural, and social change in attitudes to sex education and to promote this as a social good. In pursuing the political and social change for human rights and social justice, Ikem demonstrates in his quote above, the extensive research and gathering of evidence from what pertains in other countries and brings such knowledge and experiences to bear on advocacy in Ghana. This strengthens advocates' knowledge that they are part of a global movement and Ghana being a UN member, draws experiences from other countries to improve its policies. It is important to also note the child rights goals to make appropriate sexuality information available to young people advanced by advocates is opposed by the conservative approach to keep the education of young people to abstinence and hence the resistance to change of the policy.

Yvonne, in the excerpt below, indicated that whilst the organisation of Ikem was working directly with the Ministry of Education and the Ghana Education Service on sexuality education, his organisation and other advocates were also working on amendments that needed to be done on the same subject in the National Population Council draft policy guideline. According to Yvonne, the preparation of the guidelines was initiated by the Population Council, but women's rights advocacy groups and other NGOs influenced the final content.

Yvonne: Last year we worked on the universal periodic review and recommended that government should pay attention to comprehensive sexuality education, as part of sexual reproductive health rights. The National Population Council has a draft national guideline on comprehensive sexuality education now. Though the initiative did not come up before the review, the subsequent work on comprehensive sexuality education is being influenced by NGOs.

The extract above indicates that the campaign to have sex education recognised was also taken forward by other means (supporting consultations). The extract by Yvonne highlights the collaboration between some government agencies and NGOs Government initiates the policy guidelines and NGOs make inputs into the content. This is different from what Harriet discussed about the Domestic Violence advocacy whereby

women's rights advocates proposed the policy formulation and even drafted the Bill for consideration by the legislature and other policy-makers.

One of the participants from a government agency also provided insight into their collaboration with women's rights advocacy groups in the policy reforms process. The excerpt below is from the participant:

If you want to develop a new policy or you want to revise a new policy, of course, we work with our stakeholders. We have to make sure we bring all our stakeholders from different levels on board. The youth policy that we revised, brought our stakeholders together. (Kwasi)

The term 'stakeholders' used by Kwasi demonstrates how the policy-makers perceive and construct the roles of women's rights advocates. According to Kwasi, they regard them as stakeholders; organisations are in touch with group needs and that is what he means by bringing stakeholders from different levels. Yvonne asserts that women's rights advocacy groups pushed for the inclusion of comprehensive sexual education. The goal was education reforms that would recognise sex education as a social good. The actions therefore can include a range of policy consultations, reform campaigns, and actions to seek to achieve this goal.

From the above discussions, it is also clear that in advocating for policy reforms, women's rights advocacy groups also proffer alternatives in the process. They even could go further by sponsoring the alternatives to ensure implementation. Seven of the women's rights advocates emphasised these goals.

5.2.4 Promoting Coherent National Policy Frameworks

One of the goals of advocacy is the promotion of coherent national policy frameworks. In the quote below Emma is asserting that a goal for advocacy is not to merely influence one policy initiative but to promote system-wide national policy changes and frameworks based on women's rights.

Emma: We look at how to make policies more gender-sensitive or engendering policy, engendering legislation. When it comes to your area, reproductive health rights, we also did some work with Bill and Belinda Gates foundation way back in 2002-2004 and we were looking at harmonising the laws that promote women's reproductive health rights.

Emma indicates that such harmonisation could also be a process to make policies and legislation gender-sensitive. The quote below expands on Emma's ideas:

From 2002-2004, we did some work around advocacy and reproductive health rights. The objective was to harmonise policies and secondly to raise awareness on the issue of gender-based violence and come out with homegrown solutions as to how to deal with gender-based violence. (Emma)

According to Yvonne, harmonisation of policies begins with an audit to find out if there are existing policies, do the policies contain divergent provisions, and how they could be straightened to ensure that the policies enhance the lives of the constituents. The audit brings out such critical differences in policies to help position the policies to perform their intended role. They use human rights frameworks to critically evaluate the national policy framework and promote new standards and a common approach across policy areas. The excerpt below expatiates on the above.

Yvonne: Yes, we look at both, whether there is a law or a policy on a particular issue and whether that policy must be reformed to address current or trending issues. I can talk of the 2 main contributions we made in that regard. With HIV/AIDS, for instance, we did a legal audit looking at the existing human rights framework that protects the rights of People living with HIV (PLHIV).

Yvonne asserts that such a legal audit could also lead to the creation of a new policy which would be a harmonised document of the existing different policies on particular advocacy issues. She cites examples of the audit work done on the rights of people living with HIV. The audit recommended an HIV-specific law, and this has been done. The age of consent was also discussed under the harmonisation of policy advocacy:

Emma: For instance, we noticed a gap between the age of consent and the age a girl can get married. The age of consent is 16 years, and the age of marriage is 18, now that is a big gap and many advocacy groups have already commented that they have to harmonise.

Emma's quote raises critical issues on the gap between the age of marriage and the age of consent for sex. Emma continued to present the difficulty in the harmonization of the policies on the age of consent to sex and the age of marriage:

Emma: You either bring 16 to the 18 or you drop 18 to 16 but then the age of 16 becomes a difficult thing because the international law defines a child as somebody who is below 18, so we certainly have to move to 18 years but that is where the challenge is. We have some examples where most advocacy groups have raised awareness of the gap. It is a grey area, if you assess what our laws are and international law with best practices, we can then make these recommendations as to how some of these grey areas can be handled.

Emma asserted that in international policy documents, which Ghana has signed, a 16-year-old is still a child, and hence cannot marry. Ghana is a signatory to the UN charter on the Rights of the Child, CEDAW, and continental international charters on the rights of the child. Emma claims that a lot more women's rights advocacy groups do this kind of advocacy. The goal here is to use human rights frameworks to critically evaluate the national policy framework and promote new standards and a common approach across policy areas.

5.2.5 Promoting Legal Rights and Human Rights in the Interests of Citizens

A further prominent theme emerging from the data in several interviews was protection of the rights of people. All advocacy goals and objectives such as policy formulation, policy implementation monitoring, enhancement of services, holding duty bearers accountable, and enactment of laws are geared towards the protection of the rights of people and enhancing their access to services because it is their right. People have rights as citizens to be protected from harm and to have access to basic social services. Advocacy groups work to ensure that such rights are protected. In addition, they work to ensure that government provides the needed services that citizens' taxes are taken for.

Yvonne: Mainly we have the mandate for the protection of rights of all persons. We do that through evidence-based advocacy. We also seek to provide legal aid for persons who are abused, so we have the human rights clinic. We have a network of pro bono lawyers we work with who provide legal services on a 'pro bono' basis and that is also to encourage the indigene population to seek redress when they are abused.

Even for the poor who may not be able to afford legal services, women's rights organisations like Yvonne's provide pro-bono services so that they can seek justice when abused. This raises key issues on representation in the law courts as part of the work of some advocacy groups.

But generally, as our mandate tells us, we are here to help in the promotion and protection of the rights of others so generally that is what we seek to do in our advocacy.

Yvonne asserts that the protection of the rights of people is the goal of their advocacy. Another respondent, Harriet, also corroborated this assertion.

Our main goal is to promote and protect women's rights and to ensure that the state undertakes its obligations towards women seriously. So that is our main goal. When it comes to policy changes, we want to see lives improved, people have access to services because it is their right. People have access to information because it is their right. People can seek redress when they are abused because it is their right. (Harriet)

Harriet also indicated that protection of rights and provision of services are the obligations of the state and hence advocacy goals are geared towards ensuring the State's responsibilities towards women are upheld. Grace asserts that her organisation always uses international law and local laws to demand fundamental human rights to ensure that women and their children can access health facilities.

..., the advocacy is always about using international laws and using local laws to push for fundamental human rights and gender, helping women and their children to be able to access health facilities. (Grace)

Participants stressed that Ghana has signed onto many international instruments which seek to protect women and children. There are also the laws and policies of the state that seek to protect women. In

advocacy, such policies, laws, and international human rights instruments are used to demand that women, girls, and children are given access to dignified and rights-based services as the laws stipulate.

Women's Rights groups advance rights by also taking forward specific individual cases involving victims.

Yvonne: I remember when I started, I was taking cases for abused women and children, and we worked with lawyers to seek redress for these vulnerable groups, and we could see tangible results of our interventions in cases of human rights abuse.

Yvonne got involved in programmes that helped to attain justice for the women on whose behalf her organisation advocates. Here the advocates are upholding rights by taking forward specific individual cases involving victims.

5.2.6 Holding Government Accountable and the Mobilisation of State Resources

According to Newman (2002), the policy-making theories and analyses recognise key processes as not only agenda-setting, problem framing, and policy formulation but also implementation. In this regard, the women's rights advocacy groups in this study constructed their role as holding government agencies to account for the full implementation and support of this process. All sixteen participants attested to this. This is a monitoring role women's rights advocacy groups play in the policy implementation process. The participants presented the view that when the policy is formulated, women's rights advocacy groups monitor to ensure that the policy is being implemented properly and if there are issues, they bring them up to be addressed. The quote below is from Idris, discussing the role of women's rights advocates in this regard:

I think they have played a very important role because they have constantly reminded the government of the good things the government is doing and the good things the government should be doing, and it is not doing. They have constantly highlighted specific issues that affect some communities or individuals in certain parts of the country whose issues probably might not have been heard. This action has led to government and other development agencies' interventions. (Idris)

Idris asserted that women's rights advocacy groups play a significant role in monitoring the policy implementation process and prompting the government of the gaps in the implementation process. There is emphasis on the community focus of the advocacy process and hence a claim of seeking the good of the target groups/community members. Without their monitoring role, such issues may not have been solved. Here the advocate is highlighting the ability of women's rights groups to bring issues from the community level (bottom-up) approach to the policy implementation instead of waiting for the government to interpret occurrences. He also mentioned that in the advocacy process women's rights advocacy groups do highlight the good things the government is doing. It demonstrates that advocates are not just critics of the government's incapability, but they pursue fairness in the advocacy roles.

More than half of the participants of this study indicated that there are many policy documents, guidelines, and laws but their implementation is a challenge. According to the participants of this study, if the policies exist but are not implemented, they are as good as not being there. They, therefore, apart from advocating for policy formulation, also advocate for effective implementation of existing policies to enhance service delivery. The extract below from Idris expatiates on the above stance:

There is usually a huge gap between policy and practice with policy not adequately addressing the needs on the ground and it was important to bring this to the attention of policy-makers. So that is the role the organisation played at that time.

Idris' claim is explained regarding policies on reproductive health: "*but largely you have most of them researching what is being practised and whether it is working or not.*" Another participant, Godfred provided:

We have a law that gives access to abortion; almost liberalized abortion in a way, but the fact also remains that there are loopholes in implementation.

The implementation loopholes mentioned by Godfred include lack of political will, inadequate funding or negligence, or a mixture of all the stated reasons. Godfred stated that "*for instance, a government agency in the community, is supposed to train but they don't have resources.*" Idris also recounted that:

Probably sometimes some focus on resources, 'this is a very good policy but its implementation is so bad, maybe the resources are not sent in time or people who are implementing are not using the resources efficiently.

One of the roles of advocacy groups, therefore, is to bring the gap between policy and implementation to the attention of policy-makers for solutions. Idris's statement connotes the role of street-level bureaucrats in the policy implementation process when he stated that the technocrats and professionals implementing the policy are not using resources efficiently. Their actions and inactions affect policy implementation. Grace also corroborates Idris' data that the challenge for Ghana is not policy formulation but its implementation. Ghana formulates a lot of policies, but implementation is a challenge.

Policy-makers will make the laws, but the implementation is a challenge and I think in Ghana that is where our challenge is when it comes to implementation.

Grace continued her discussion by raising various questions about the 'how' of implementation. The 'how' of policy implementation as asked by Grace, could also highlight the effectiveness of implementation. For example, are all intended beneficiaries getting access? Access does not only relate to cost and distance. Access can be hindered by so many factors; transportation cost, service fee, and sometimes the professionalism or attitude of service providers which 2 participants termed 'violence from the health

facilities'. Idris for example recounted how women in some ten communities stopped accessing antenatal services in a particular facility because the staff there were abusive:

Idris: We went to 10 communities and had focus group discussions, they mentioned that when they go to the OPD, there was one woman who gave them their cards. She was so abusive and always insulting and sometimes, they had to pay GHS5 else she would let them be in the queue for long. This was reported in ten communities. So, some of them were not going there. They preferred to deliver at home...When you go, and you are insulted and abused you would not want to access services there.

Apart from access, Grace explained that the knowledge of service providers of the policy is also critical as well as the 'simplicity' of the document for easy comprehension. She refers to this as the 'friendliness' of a policy. According to this participant, a policy could become difficult to implement not because of lack of money but because the policy document may be difficult to understand. If the policy direction is not clear in the document, it is termed as not being friendly to users. This affects the implementation of the policy. According to the participants, there is also a need for proper dissemination of policies so that service providers will know about its existence and its provisions and be able to invoke the spirit of the policy during service delivery. Some participants also assert that advocacy for implementation of policies monitors implementation and reports to stakeholders. This ensures that policy-makers do not leave the policies on shelves. The quote below from Idris evidences this position:

Idris: Some also monitor implementation and will just report on what is working or what is not working well and needs to improve Probably sometimes some focus on resources, "this is a very good policy, but its implementation is so bad, maybe the resources are not sent in time or people who are implementing are not using the resources efficiently."

Ama, who is also a women's rights advocate claimed that "*many policy-makers are aware of the issues but what is lacking is the interventions that need to be put in place.*"

The monitoring process finds out what aspects of the policy are working well at the implementation stage and what aspects are not working well. Monitoring reports highlight areas that need improvements. According to Idris, the monitoring also looks out for resources that are not sent on time for implementation. This reflects Dye's (2010) definition of policy as including what the government chooses not to do.

According to several groups in this study monitoring policy implementation focuses, not only on programming but also on resources. There could be cases, where the release of resources for the implementation of policies delay and this makes implementation of the policy difficult. Another important aspect of resources is their appropriate use. Idris, calls it 'efficient use of resource'. According to him, efficient use of resources is critical in the successful implementation of policies. In this study, some of the

women's rights advocacy groups stated that their key role was to monitor how resources released for policy implementation are used. There could be cases where the implementation of policies could experience challenges not because there was no funding but because funds were misapplied or inefficiently managed. When women's rights advocacy groups in this study identify such issues, they bring them to the notice of policy-makers and demand the efficient use of resources.

The participants of this study affirm that advocacy on the cost of policy implementation may also be on the need to reduce the cost of services. If the money women are to pay for services, for instance, ante-natal services are too high, they may not access services. So though in principle there is a policy for free ante-natal service delivery, in practice, women could be asked to pay for aspects of services because funding has not been received from the government. According to participants, advocates follow up on all these issues and plan advocacy actions to demand changes and adjustments to enhance access to service delivery. A participant provided more insight in the excerpt below as he discussed the barrier that subscription to NHIS could bring in the implementation of the health insurance policy:

Idris: We needed to make healthcare free at the point of use. It was not enough to say that there is free maternal health. We realised the subscription payment was in itself a barrier because we realised some people could not afford the money, even though a certain class could. It was a limiting factor. And then we said it was unfair that people were already paying VAT so whether we supplied or not, we were already paying and that for those in the formal sector, we were already paying for it but needed to still pay something to the scheme.

The inability of people to pay for NHIS subscriptions demonstrates inequality in the larger economy of Ghana which also leads to inequality in the health care system, especially the feminisation of poverty (Asante and Zwi, 2009). So, though the National Health Insurance scheme seems to be a universal health policy for all Ghanaians, the cost affected implementation since many were not enrolling in the scheme. The argument by advocates to abolish payment of NHIS subscription was based on the fact that there was already a component of Value Added Tax (VAT) and pay as you earn (PAYE) on the salaries of formal sector workers. This advocacy was therefore to ensure economic justice which would affect health outcomes positively by improving access. Though this advocacy did not yield the intended results as people still pay yearly premiums for the national health insurance, it raised the issue of the need to explore more funding possibilities for health and enhance universal access to healthcare. The issue from time to time appears on the list of alternatives for consideration.

Another participant shared the advocacy work her organisation pursued in the implementation of immunisation of children to demonstrate advocacy towards ensuring efficient and effective implementation

of policies. For the participant, according to the national policy, all children have the right to be immunised but women's rights advocates realised that the Ghana Health service alone was not able to reach every child in Ghana with immunisation. According to Grace, the advocacy goal was, therefore, to demand that the government involves Civil Society Organisations in the implementation of the policy to ensure that every community and every child was reached:

Grace: We have a policy for immunisation, every child must be immunised. It is a government policy, but we realised that Ghana Health Service alone was not able to reach out to some of the hard-to-reach communities. We started our advocacy discussions, it took a long time, but we started lobbying, we started organising consultative meetings, we brought Civil Society together, and we got a lot of mothers to see that the resources and immunisation is their right, so we mobilised all those people as our allies then we brought in the media.

There is a clear case of the inability of the government to be able to reach all communities and ensure immunisation is delivered from a rights-based approach where children in hard-to-reach communities are not left out. Again, the extract shows that women's rights organisations participate in delivering services as they advocate for equal distribution of resources and services to ensure the poor are not disadvantaged. Grace asserted that; *"a lot of resources come to this country"* but they do not reach the communities. She continued that all the series of advocacy engagements on the implementation of the immunisation policy; lobbying, consultative meetings, demonstration, and presentation of a paper were to ensure that every child was reached.

The above advocacy went beyond seeking effective policy implementation to ensuring the whole political process is effective and accountable and promoting women's and children's rights.

I think in totality, the voices of NGOs hold the government to account, where they promise, and they don't do what they promise. Where HIV or domestic violence issues are taken lightly, the coalition voices always hold the government to task, accountable in terms of policies and making funding available. (Harriet)

The women's rights advocacy groups, therefore, undertake policy scrutiny roles on what the government chooses not to do or not doing well and advocate for the government to act.

Closely linked to advocacy on policy implementation is advocacy for promoting rights and access to services and social goods. The section below expands on how women's rights advocacy groups construct this goal.

5.2.7 Promoting Rights to Access to Services and Social Goods

Five women's rights groups in this study said they engage in advocacy because the change that they advocate for is needed to enhance their work. Such organisations were set up primarily as sexual reproductive health service delivery organisations. But during the delivery of services, according to the participants, organisations encounter structural and policy-related challenges that negatively affect the delivery of services. The groups, therefore, engage policy-makers for specific policy gaps to be filled or demand that the implementation of existing policies is enforced.

Linda: You know my organisation wasn't set up to be an advocacy organisation but then as we started working, within our work, we realised that there are certain needs; specific things to be addressed and we needed to also advocate to ensure that the work we do also has the necessary input.

Linda explained that her organisation aims to ensure that people were well informed about matters that relate to their sexual reproductive health especially HIV and other STIs. The organisation also provides clinical services. Linda gave a specific example of advocacy for antiretroviral drugs. She said her organisation spearheaded the advocacy to ensure universal pricing of ARVs.

We were then battling the issue of the cost of antiretroviral drugs. We didn't understand why government hospitals should be able to give them at a reduced price and NGOs would have to give them at a much higher price. So, it was an issue; how to give quality care to our clients. We went together with the National Association of People Living with HIV (NAP+). We were advocating very strongly that they should allow universal pricing in antiretroviral drugs at that time it was pricing problems, so we went to the National AIDS Control programme, met with them, sent all sorts of letters, then we had to have a meeting with the Country Director of CCM, which is the platform for the Global Fund for Malaria, TB and HIV. (Linda)

According to Linda, this advocacy sought to correct structural service delivery policy defects that promoted inequality where government facilities could give ARVs at a cheaper price than private facilities. As an organisation that runs its own HIV clinic, this unequal pricing was detrimental to its service delivery and access to services and commodities. Linda's organisation led the promotion of equal rights to ARVs as social goods. Again, conducting this advocacy with NAP+ which is the parent support group of beneficiaries of the ARVs gives credence to the meaning of advocacy as projected by some of the participants that the affected community is crucial in advocacy. Advocacy is conducted with the voices of the beneficiaries. The targeting of the right policy-makers is demonstrated as useful in achieving results. The CCM is important in this advocacy because the Global funds substantially support HIV programming including Antiretroviral drugs in Ghana (Opoku et al, 2017).

From the above account, it is evident that the successful implementation of the projects of Linda's organisation or successful delivery of services is enhanced by advocacy. The importance of such advocacy

is to remove policy bottlenecks or funding challenges so that the delivery of services could be carried out without many challenges.

In the excerpt below, a participant engaged in advocacy to ensure that delivery points of adolescent reproductive health services are friendly. As reviewed in the literature, the Maternal Health Survey (2017) indicates that 14% of women and girls aged 15-19 have had a live birth or are pregnant with their first child. Sandra explained to me that her organisation advocated for a day to be set aside for adolescents to go to the health facilities for maternal health and family planning services. According to Sandra, most Ghanaian cultures frown upon teenage pregnancy and hence pregnant teenagers are shy to access ante-natal and post-natal services because they would meet adults who would insult them or ridicule them. Such advocacy is therefore usually on the district or facility level where duty bearers are engaged to ensure changes that enhance access to services. Sandra's quote below evidenced her claim.

Sandra: How do we ensure that the service point is friendly? It was not easy to get the health directors to make sure that there is a day set aside for adolescents to go to the health facility for services. When you get to the facility, 14 years, 15 years, they are all pregnant, and some of them will say even my friend is gone to the other facility because here she is shy. Who is holding them accountable? So, we need to put them on their toes.

Sandra raises a critical issue on accountability in her excerpt above. Advocacy is not only for policy change at the national level but at the district and community levels, advocacy enhances service delivery as duty bearers, who Lipsky (1980) would call street-level bureaucrats are called to deliver government policies and programmes with a professional outlook and with the knowledge that they are accountable to the government and the people. According to Sandra, accountability raises the concept of rights and that the service providers are put at their stations to serve the citizens. On the friendliness of the health facilities, Sandra said:

You know nurses sometimes talk to patients in a way that dispels them from the hospitals. We want them to come to the facility. It should be a friendly environment for the reason why the person is accessing the facility. So, at any point in time, the person is ready to come and even lead others.

Godfred, another participant, shared another advocacy action that focused on quality services and 'friendliness' at the facility level. In the excerpt below, Godfred indicates that the attitude of health workers at the facility levels affects the achievements of national targets and the lives of women.

You know the UN mortality rate target was 85/100,000 births. We have not achieved it. We are now around 319/100,000. We have done very well. I will not say we have not done well when we look at the base from about 700/100,000 in 2014. So, we went out to advocate with the hospital staff, engaging the health facilities to understand their attitudes to the needs of those accessing the facilities; that the rights of the person accessing the facility should be upheld. (Godfred)

Idris also discussed the attitudinal problem at the facility level, and he called this violence:

Now there is another form of violence that I want to talk about and that is also an issue, violence against women by healthcare providers. ...We went to 10 communities and had focus group discussions. (Idris)

The situation described above prevents women from accessing healthcare. The facilities are not friendly because the staff are sometimes abusive. Women, therefore, prefer to deliver at home. There could be a policy on free ante-natal care or even national health insurance, but the attitude of health workers could prevent the achievements of the policy initiatives. The respondent provides his opinion on the violence at the health facility:

Idris: When you go and you are insulted and abused you would not want to access services there. NGOs working in reproductive health have talked about it but they do not talk about it as violence against women, they talk about it as the attitude of healthcare providers towards patients and so you see that framing is different and hence sometimes it is lost in the discussion. Because it is violence because if it is home that I insult my wife and abuse her that is violence. Sometimes they hit them so we should look at the violence that is happening at the facilities.

Idris explains the concept of framing in the advocacy process and its ability to influence how issues are kept on the agenda. If issues are defined as violence, there is a likelihood that it would receive urgent attention than when it is framed as the attitude of health workers.

From the above discussions, participants, work towards a goal of widespread healthcare reforms to ensure rights to services and improved quality of services.

5.3 Levels of Advocacy

Many participants mentioned that there are different levels of advocacy. Advocacy is not only from civil society to policy-makers or government, it is on various levels and in various spheres. Even if there is the need for policy change or implementation of policy, advocacy takes place on various levels with various actors to achieve the needed change. According to the participants it is through the mobilisation of people that a strong voice is built for policy-makers to hear. The data from the background information on women's rights advocacy groups gathered showed that 11 organisations were district/community-focused, 7 were regional focus, and 17 were national-level organisations. Some organisations work at multiple levels: international, national, regional, and district or any two of the four. But the majority are national-level organisations. Three of the organisations said they operate at the international level also. The data from the qualitative interviews provide various scenarios where organisations work at various levels. Augusta, a UN

worker, and Sandra, the women's rights advocate who demanded adolescent-friendly services, shared their perspectives:

There are different levels of advocacy. We have policy advocacy which is done usually at the national level. Where you want to influence policy, or the policy is there but is not being implemented so you want to bring focus on implementation. (Augusta)

Our advocacies are targeted first, at the national level and then the district level, then we are also doing it at the facility level. (Sandra)

This means that some advocacy, especially from those that seek to influence policy change, is done at the national level where policy-makers operate. But when an advocacy activity seeks to either monitor or enhance implementation, it usually targets the district and the community levels. The levels of advocacy could also be influenced by the decentralised system if government is decentralised at the regional and district levels. Each region has a regional Minister with accompanying technocrats of various levels. Each district also has a District/Municipal/Metropolitan Chief Executive Officer, representing the President, with technocrats of various levels (Mayhew, 2003). Emma shared her experience:

We turn to look at the various levels of power within the areas that we are working. We usually work in the communities, we work with the traditional leaders, we work with opinion leaders, we work with DCEs and district assembly, and then before we come to parliament. (Emma)

The above excerpt suggests a proper analysis of the various levers of power in the cause of the advocacy action and that achievement of the advocacy outcome or results can be at various levels. Emma also said that in her organisation:

We identify the various powers, the various hierarchies in the systems, and the communities then approach them and engage with them. We found out that it is very effective working with people at the grassroots, they can affect a change, even more than those at higher levels because they are now also going to get the support from others and then get to know the issues that we lay down. (Emma)

The mention of grassroots is profound. She claims that advocacy at the grassroots is effective because the needed change which has to be done by the community people themselves can be achieved immediately and with better results than with policy-makers at the 'top'.

The above discussion of levels of advocacy had mainly focused on geographical and systemic categories. However, in the excerpt below, Mabel provided another description of levels; systemic, which demonstrates the proper analysis of stakeholders and actors. Firstly, she states presidents of countries, first ladies, the legislature, the judiciary, good male voices, key women in government, young people's voices, people living with infections, traditional leaders, and the media.

With the list of policy-makers, other policy actors, and target groups, Mabel demonstrated that advocacy could be carried out on all these levels toward the intended results. This gives an idea of how high level the advocacy issue was constructed. Again, the policy-makers that Mabel's organisation could reach is a demonstration of how powerful the organisation itself is. Being a government agency, this is highly possible. This also brings to the fore that it is not only women's rights advocacy groups who do advocacy but some of the government agencies and commissions also advocate on their mandate to help set priorities, keep the mandates of their organisations on the agenda and get various voices to support their programmes.

Mabel mentioned the inclusion of male voices in their advocacy. Male involvement in reproductive health advocacy is highly encouraged especially in a culture like Ghana's which is highly patriarchal. Men still make critical decisions on family planning and other reproductive health-seeking behaviours. (Adomako Ampofo, 2008, p. 405; Akumatey and Darkwa, 2009). This evidence of abuse by men necessitates their involvement in reproductive health and violence against women programming and advocacy to ensure that the main perpetrators are empowered to deconstruct the patriarchal systems that support male domination which leads to abuse of women. Mabel's excerpt is below:

We had to recruit advocates of these key people including the Presidents of 2 governments, the first lady, members of the legislature, the judiciary, that is all the three arms of government, key women in government, good male voices in government, because of the gender perspectives, young people's voices, people living with the infection or disease, people affected with the disease directly, media voices. We had to recruit traditional and religious leaders (respected voices), we had to recruit health service leaders, and we had to work with activists from the grassroots. (Mabel)

Traditional leaders (chiefs and queen mothers) are very important in advocacy in Ghana. They are custodians of the customs, traditions, and community by-laws of gender relations including the institution of marriage, women, and economics, and women and decision-making. Perceived as possessing authority from the gods and being from royal families, they carry power and are heard. Advocacy efforts that target traditional leaders, including queen mothers, ensure their buy-in and assurance that gender-related bottlenecks to the wellbeing of women and girls in the communities are removed. In this regard, they are both targets to achieve results and added voices to advocate with the government.

All the above discussions on policy have been activities within the country. Yvonne, however, presents a different concept of policy reviews/reforms called the universal periodic review which involves the United Nations and other countries and hence operates at the international level:

Yvonne: The universal periodic review is like a framework at the UN level where coalitions of NGOs can submit reports from their countries to be reviewed and States make recommendations to other States on specific things they want to be changed in their countries. So, what the NGOs did on sexual reproductive health was for us to submit certain recommendations through these mechanisms and then to ask for other states to make a recommendation to our government, which they did.

Yvonne indicated that this level of advocacy also worked because through this mechanism, Canada made recommendations to the Ghana Government on sexuality education and would support the government to implement the recommendation through the UNFPA office.

For instance, we are aware that Canada is going to support Ghana, through the UNFPA, they will give money to the UNFPA to support the government in sexuality education because Canada made a specific recommendation to the Government on sexuality education. So now we are moving into how other mechanisms can influence the policy of the government. (Yvonne)

Kwasi, who works in a government agency highlighted the importance of this process and stated “...*they have a country position paper to the UN, so when you talk to their staff, they can give you more insight.*” The ‘they’ in Kwasi’s statement refers to women's rights advocacy groups. His response demonstrated the close work of government agencies with CSOs including women's rights advocacy groups. According to Kwasi because the agency was abreast with the work of the NGOs, it was aware of the report to the UN mentioned by Yvonne. This may be because they are usually the target of the advocacy work done by the groups. Kwasi’s response also revealed that reports submitted to the UN by women's rights advocacy groups include a position paper on key issues as they call for support for their country.

The discussion of the data on the levels of advocacy has also highlighted the top-down, bottom-up approach to policy-making. The analysis of levers of power and the targets of the various levels (national, regional, district, and even international) and various systems and actors give credence to the importance of working from both sides as particular issues demand (Pressman and Wildavsky 1984). A bottom-up approach to policy-making is recognised by the women’s rights advocacy groups as they apply their advocacy along those lines to be able to achieve their goals.

5.4 Conclusion

Overall, the chapter has explored the perspectives and experiences of women’s rights advocacy groups on reproductive health policy-making and implementation in Ghana, and the link between violence against women and reproductive health. Key findings that emerged are advocacy is about change across the whole policy system as well as society and in terms of the policy-making process making it more community responsive. Participants took advantage of problems such as murdering of women, rape and inactions of

government concerning women's security and improved reproductive health services and developed advocacy actions for government to act. The problem identified was the insecurity of women and girls and the government's action was needed to solve it. This finding corroborates the key tenets of the problem stream of Kingdon's agenda-setting (Kingdon, 1984). The participants of this study sought to improve rights and justice and health via these changes. Advocates in Ghana operate to influence and shape all aspects of the policy process. Advocates are more involved in achieving improvements in policy and services than is often recognised. They operate at all levels of governance and policy - the local, national, and international arenas. This is because the international context of human rights and international funding is key to national-level politics. It is worth noting also, that women's rights advocates perform responsibilities that in many jurisdictions, are reserved for policy-makers, for example, drafting Bills for presentation to parliament. This is important and unique to the Ghanaian advocacy context, and it underlines the need for experts in the advocacy process operating at all levels (Joachim 2003). The next chapter examines how these goals of advocacy are pursued in terms of strategies used in the advocacy process.

CHAPTER 6: FRAMING AND STRATEGIES OF ADVOCACY GROUPS FOR POLICY CHANGE AND IMPLEMENTATION

6.0 Introduction

The chapter explores the question ‘how those within advocacy groups construct and frame the problems of inadequate reproductive health rights and services and violence against women; and the proposed/preferable policy changes and alternatives? As a continuation of chapter five, the chapter explores how advocacy groups frame their advocacy messages as they push issues onto the policy agenda. As highlighted in the literature reviewed, framing and the use of evidence in advocacy are all part of the strategies of advocacy groups. Using the concepts of feminism, gender inequality, women’s rights or child rights, the chapter discusses how women’s rights advocacy groups, as policy entrepreneurs, navigated the policy-making processes as they employed a particular gender, feminist or rights approach or neglected a particular framing of feminist depending on how ‘fit for purpose’ it was and how they perceived the acceptability of such concepts and its effects on the advocacy actions they pursued. Through their data, key concepts of power, patriarchal relations and its impact on policy-making is analysed Crenshaw (1991). Gender stereotypes especially on the meaning of marriage and its implications for the rights of women are discussed. Again, the chapter explores how those women within advocacy groups, acting as policy entrepreneurs, used access to grassroots information and data in general to accentuate their power over the issues they advocate on and demonstrated to policy makers that they were not just working on sensationalism but had real data to give credence to their claims.

Secondly, the chapter also answers the question “what are the tactics/strategies used to achieve advocacy outcomes, especially the strategies advocates perceive as important and why they understand and pursue these strategies?” These strategies/tactics, apart from framing and evidence generation, discuss strategies to reach policy-makers with the advocacy message and hence are access strategies. Strategies in this context refer to a sequence of actions and exchanges that increases the opportunities for advocacy proposals to be accepted (Jansson, 2016). The importance of media in advocacy in Ghana is also discussed as advocates demonstrated their application and need focusing largely on traditional media.

6.1 Strategic Framings of the Advocacy Message to Achieve Policy Change

In exploring the agenda-setting of interest groups, framing is important in understanding the perspective from which a policy problem can be understood, presented, and acted upon (Davitor, 2007). To have policy-

makers accept the advocacy agenda and take action, women's rights advocacy groups strategise and think through how to present the message so that the policy-makers will receive the advocacy action as important and respond positively to them. This section presents how advocacy groups frame their messages and the intended effect a particular framing is expected to achieve. Corner and Hahn (2009) assert that framing might influence the persuasiveness of the message and hence its success.

Framing of the advocacy messages in this study considers how participants of this study present framings and what they try to achieve by these framings and why do they see them as useful in this context. It explores how the framing of the message was used to gain persuasiveness and to make the message acceptable to policy-makers. The main framings explored in this chapter are reproductive health as a gender issue, women's rights framings, human rights framing, economic framing, children's rights framing, and evidence-based policy framing.

Evidence from this study suggests advocates purposely consider how to frame their messages to achieve the expected results. Alberta, in the quote below, shared this perspective:

I think that when an issue requires advocacy, you just don't get up and implement it, you must sit down with your people to understand the problem and what strategies to use. So, yes, framing is important. If it is more of a gender issue, how can we get to the Ministry of Gender for example? ..., what strategies do we need to get to them? (Alberta)

Alberta states that framing is done by sitting down with "your people". This connotes a very important strategic exercise. The opinions of all advocates in the advocacy action or the coalition are sought, and the message is crafted to achieve the intended goal. The extract above from Alberta also indicates that consideration of the policy-maker is important in framing. The policy-maker's knowledge, his/her major work, his/her ideologies, and the role they play in the policy-making process need to be known during the framing. In the quote above, the example given is that if the Ministry of Gender and Social Protection is the target decision-making office, even if the advocacy is on reproductive health, the framing would necessarily have to consider gender seriously and see how policy can be positioned to address the issue.

Alberta further states that framing is the categorisation of advocacy messages. The categorization helps to identify which key people with which expertise are to carry the messages to the right decision-maker. In the quote below, Alberta expatiates on the topic:

So, I think it is very important. You need to categorize, whilst you frame it or categorize it, into whichever category, then you can get key people with that expertise of working with which people. Even in reproductive health, we are talking about men, how do we target men to make sure that they are involved? Even in some countries, they are even rewarding men who accompany their wives to the clinic. (Alberta)

In the extract above, Alberta mentions that depending on how the framing of reproductive health advocacy messages is done, male participation in reproductive health programming could be enhanced. For that reason, then, framing issues as reproductive health will be more appropriate and more rewarding.

Framing goes beyond categorization. Framing aims at ensuring the proper packaging of advocacy messages to provoke the needed response (Entman 1993). In the section below, the main framings discussed are women's rights framings, reproductive health as violence against women and gender issues, human rights framing, children's rights framing, evidence-based policy framing, and multiple framing.

6.1.1 Reproductive Health and Violence Against Women as Women's Rights

Two women's rights advocates said they frame their issues as women's rights. Harriet, in the quote below, shares their strategy in framing. According to her, their organisation has always been passionate about women's rights so that is how they frame it. But to be able to focus on women's issues, they research the issues to see which gender is more affected and use data to back their advocacy.

We have been more than passionately supportive of women's rights, so all our work has been on promoting women's rights and that is how we have always positioned ourselves. Yes, gender is fine and that is where the research, the data helps, because if you have data that shows clearly whatever issues, how it affects women and how it affects men, in any case, it ends up with the women being more disadvantaged, then you can use it to push the women to drive the agenda. So that is what we have always done. We always get this fiat that gender is not about women only but men also and we tell them, yes, but when you see the disadvantaged one, you bring that one up. (Harriet)

Harriet provides that data has always shown women being more disadvantaged in reproductive health and violence issues and hence has provided the basis to push an agenda for women. Gender is not only about women, but the evidence through data shows clearly that women are disadvantaged and hence a focus on them in the advocacy action is appropriate. Another respondent, Linda corroborates the assertion:

Then we had also, but that was on a small scale, advocated for the rights of HIV positive women because when we were seeing them daily. We saw that women who come do not know their rights as women; women having access to health care, and how they can stand for their rights. They were always so dependent on the men.

In the above extract, Linda demonstrates that by framing as women's rights, advocates could also be specific about which category of women to frame their advocacy messages around. In such advocacy therefore the question does not arise on the 'how' to frame the advocacy message because the whole advocacy is set out to improve access of HIV positive women to health care.

6.1.2 Reproductive Health and Violence Against Women as a Gender Issue

More than half of leaders of women's rights advocacy groups, two policy-makers, and one UN Worker discuss the framing of sexual reproductive health and rights issues and violence against women as gender issues. Participants reveal that they usually choose gender as the keyword in framing their advocacy messages on reproductive health. According to them, gender connotes inclusion, and hence policy-makers respond to such framings. Grace, the participant who discussed immunisation of children expands on this and provided the reason which is below:

sometimes when you say women, or if you only say children, they don't respond but the moment you say gender, they look at it that "we are also part of it". So, you have to be very strategic when you are raising some of these issues. (Grace)

In Grace's advocacy, gender is the strategic term for the framing of her advocacy activities. For her, when advocates start with gender it gives comparably easy access to the minds of policy-makers, who are predominantly men.

You must start with gender where they (policy-makers) see themselves as the beneficiaries of these policies before you can narrow it down to which area you want to. But the moment you start talking about feminists, and women, they shut down, so you must start with gender issues and then you narrow it to women's issues. (Grace)

Grace claims that when women or children are used in starting framing, the response may not be achieved. Gender is appealing because the policy-makers (who are mostly men) also find their needs being taken care of and hence respond adequately to such framings. Gender is therefore used by her organisation as a starting point to get the attention of policy-makers before narrowing it down to specific framing. Gender as framing becomes more acceptable because everybody seems to be part of it. Sandra corroborates this opinion and shed more light on the framing as gender. When asked if the particular framings affect the outcome of the advocacy action, Sandra responded in the affirmative and quickly added that she does not present her issues as feminists or even as sexual reproductive health, but she usually presents her issues as gender:

Yes, it does. I don't present my issues as feminist; I don't also present as sexual reproductive health. I present my issues as gender because when we are talking about gender and reproductive health it doesn't only affect women, it affects men as well. Some may not even know that if we have reproductive issues, it affects men, so that is why I said male involvement is needed. When I am presenting to any policy-maker, I tried to show the benefits to both men and women, though the woman is vulnerable. sometimes, I am surprised by those in charge of policies, by the time we go, their committees are all men, and only one woman is on the committee, so we must be more strategic. (Sandra)

Sandra and Grace demonstrate that Gender is an inclusive framing. It allows for analysis of both males and females in reproductive health programming. Both advocates confirm the negative impact of the low representation of women in the policy-making realms as stated also in FAO's report (2012). Membership of committees in decision-making realms is dominated by men and hence a choice of an all-inclusive term is strategic to initiate conversation else it is difficult to achieve advocacy results. She states that "we *have to be strategic*". Sandra opines further perspectives in the quote below:

How are the issues we are engaging beneficial to the society at large, and not just women, because when we go, they say 'you people, women, women, women, always women? I remember I went to Koforidua Regional Office when we were doing the gender and HIV and I said 'oh, Kakdi was going to walk through the whole of Ghana to create awareness on women's issues, they said 'oh, you gender people, women, women. Now my wife can even get up and talk to me anyhow. So you see we have more men in positions so the packaging of the information. Men should also see that they have a responsibility, and they are part of it and at the end of it when they see that, they will buy into it. (Sandra)

In the above quote, Sandra presented a key gender stereotype and how men think of the agency of the woman in marriage. A policy-maker perceives women's rights framing as an affront and states that the work of women advocacy groups has made their wives talk to them anyhow. These stereotypes regarding women as inferior who should not be able to stand for themselves can lead to violence (Kaye *et al.*, 2005).

When asked about the framings of women groups when they approach the government establishment on advocacy, a policy-maker, Odo, said that they are mostly seen as gender experts. The government establishment's focus is on what the women groups can do with the government institutions and not how they frame their issues. Odo's extract below expatiates from the standpoint:

We see some people as gender experts. We work with gender experts so if somebody is a feminist, that is not our case, gender equality, that one we are not looking at the person's feminist or partiality. What the person can do for us is what we look out for. (Odo)

From the quote above, Odo suggests that feminist framings present partiality. This is important to note because Odo's establishment is expected to understand women's issues and hence her stand on feminism has implications for women's rights advocacy groups. This provides insight into the reasons why women's rights groups prefer gender as the framing. Many participants vehemently stated that they do not frame issues as feminist. This response from Odo who is a woman negates one of the reasons given by Grace and Sandra on why the framing of gender is preferred. They said that most of the decision-makers are men and hence would want to see how they also benefit from the discussions. But Odo is a woman, and she also does not favour feminist framing. This elicits a key question in the feminist standpoint of whether an increase in

women in decision-making realms translates into the representation of women's issues (Tinker, 2004). The perception of feminist framing in Ghana needs further inquiry.

Another participant, Dzifa, the policy-maker who discussed CSOs' involvement in policies on family planning in chapter four, confirms that gender framing is all-inclusive. If there is framing in reproductive health, it is primarily on gender, because gender is all-inclusive. But she asserts that women's rights advocacy groups frame in many different ways and this is holistic.

Dzifa: All put together. Because if you talk about reproductive health, it is gender, it is right, it is women. It is everything. They present it in all ways. You cannot take rights out of reproductive health; you can't take gender out of reproductive health. They present it holistically.

In contrast, however, Alberta, a UN worker, warns against gender being the common framing for its strategic stands as an entry point to discuss issues. She noted that every issue is being framed as gender including LGBTI issues. According to her, this also can affect advocacy negatively because of the culture. The quote below from her evidences this stand:

LGBTI issues and everything is being brought to gender. We are a people of culture and even though some of these cultural issues are negative, it is the negative part we are looking at. Gays also have their rights but that needs to be considered as a whole cohort. If you bring everything to the table of gender or women's rights, where some of these issues are very sensitive then you get pushed back. So that is why we should also be aware that there are pure gendered issues. If it comes to sexuality, they are also another cohort, and we should not discuss it along gender. When you bring everything to the table of gender then you defuse with others. Then they say oh, these are the gays, these are the lesbians. (Alberta)

From the quote above, Alberta proposes a delineation of purely gender issues from sexuality and other advocacy issues so that issues that are purely women's or men's issues will be treated as such. Alberta's quote indicates that sexuality is a sensitive topic in the Ghanaian culture, and it stands to impede the advocacy process if it is discussed under gender. The culture of a people therefore should inform the framing to achieve the intended effect. Emma, the women rights advocate who discussed the formation of Sisters Keepers in an era of serial killing of women corroborates the influence of culture on framing:

Also, we realize that our culture determines how we even frame our messages. When it comes to human rights laws, people hardly know about them. People don't know some of our laws, so we make sure the framings are done within the background of the culture. (Emma)

Emma's extract demonstrates a culture of ignorance of the law on rights. This connotes a low background of education for women and hence their access to information on their rights. It also connotes a culture that impedes women's access to information on their rights and reproductive health. Both Alberta and Emma hence discuss culture, but their angles are different. As Alberta examines culture from the philosophical

perspective and belief systems of the Ghanaian, Emma also discusses culture from the angle of women's access to information and hence alludes to women's access to education and decision-making realms. In the quote below, Mabel, also a policy-maker confirms gender as the preferred framing:

Mabel: Gender is not just about women only but women's and men's issues. But because of the indications of our epidemic, we had to focus on women, but we cannot route for women except men's needs were also met. So, we looked at gender, not feminism. So began to take a very good look at gender in 2010, 2011 and a couple of years after that.

According to Mabel, gender as framing allows the discussion of both women and men in the policy-making process.

6.1.3 Multiple Framing

Following Dzifa and Alberta's quotes above discussed under gender framings, there is evidence of multiple framing of advocacy issues by women's rights advocacy groups. Some organisations frame issues from multiple perspectives to cover all salient issues in an advocacy action. The extract below provides insight into multiple framing.

We normally deal with gender, reproductive health, and human rights laws... If it is gender, it is human rights, so it is important to always get it right. Even sometimes, those who are in positions may not know about the human rights laws, so you need to put them in a room, you educate them about the laws. They then come to understand and appreciate where you are coming from. If you don't do that, and you just go along gender, you find backlash coming up, so we need to put all these in perspective. Normally we like to use our phrase "the human rights approach". The "human rights approach" always sets the tone for us and always makes it easier for people to be more receptive to the messages we send out. (Emma)

Since there may be framings such as human rights law, some politicians may not have full knowledge of the advocacy issue. Advocates need to educate the decision-maker on the framings so that they can appreciate the advocacy action. In the absence of that, there could be what she describes as 'backlash' (counter actions). In these multiple framings, Emma's organisation uses the human rights approach to encapsulate gender as framing to avoid 'attack' from the target group. The human rights approach sets the tone for people to be receptive to the main framing which is gender. The description given by Emma connotes a detailed strategic exercise that considers many angles and positions from the view of the target decision-makers before issues are framed and put on the agenda. In the extract below, Augusta, a UN worker, asserts that she usually uses 'rights' as the main framing and gender becomes a sub-framing to give focus on the disadvantaged group:

Not feminist. We normally say we want to have a rights-based approach to programming. Gender-sensitive so we look at the issues, for example, the issues of family planning. The government is not putting funding into family planning. When the advocates are coming to talk about it then it is more

of getting the health-related CSOs, the coalitions of NGOs in health or others to tackle that aspect or having family planning on the NHIS then we have PPAG and others to lead the cause. Usually, they will bring the issues and say these are the challenges we have then we say ok, let us see if we can do something about it. (Augusta)

From her perspective as someone who works with the UN, the organisations appear more from the reproductive health angle, using the right-based approach as the main entry point in framing. However, some issues are gender issues and those issues are framed as gender. According to Augusta:

they can even come to us and say we want to advocate for this, can you help us? But when it comes to an issue like child marriage, gender-based violence, you know that it is gender.

It is however important to note that no women's groups were framing as feminist though Felicia described herself as a feminist. Feminism seems to be a term no organisation ever wanted to use as framing in its advocacy activities. Augusta, in the earlier quote, says '...not feminist'. In the quote below she states emphatically that framing depends on the issue but "don't say 'feminists' because we are working with the population, reproductive health, and gender, where the issues apply". Augusta indicates that one of the advantages of multiple framing is to allow for integration in the programming of reproductive health. Gender, population, and reproductive health as framings allow for many areas of the issues to be approached from an integrated point of view. For example, when a reproductive health issue is being tackled, it is important to look at gender because some women may not be able to access medical facilities because of underlying gender limitations. Mary, another UN worker, shared the data below:

I know where you are going because here is a country where they will want to make everything look like it is foreign and these are foreign things, ideas that they are bringing in. So sometimes, we tend to make it for people to accept it. ...and that presents the issues in such a way that people will accept them. (Mary)

The excerpt above connotes a compromise sometimes in the framing of the advocacy issues. What is keen to ask is the effect of such compromises on the advocacy action and to what extent should such compromises be made. The effect of culture resonates here as Mary states that many ideas on gender and reproductive health or even violence against women are perceived as foreign ideas and hence advocates are faced with compromises to make headway with their advocacy actions.

In all the framings above, many participants mentioned evidence as important in knowing which gender is more affected by any policy issues. The section below discusses the importance of evidence in the advocacy process in Ghana.

6.2 Evidence-Based Advocacy

In this research, participants presented evidence in advocacy as a strategy and a framing for effect. Some advocates indicated that evidence gathering is one of the main roles of advocates. Evidence is gathered through research and the work of advocates at the grassroots. The data presented also indicate evidence-based advocacy as a framing of the advocacy issue, appealing to being scientific and objective to present claims as ‘rigorous and valid’ (Storeng and Behague, 2014). This section analyses data on evidence-based advocacy from nine participants who are women rights advocates, UN workers, and policy-makers. Analysing the data from all these angles provides a holistic view of the concept from the advocates' point of view and the policy-makers' point of view.

Grace and Linda's responses below provide insight into evidence perceived as a prerequisite for advocacy and the role of advocates. Grace, responding to the role of advocates opined that:

To be a non-state actor, to say what I have to say, especially if I have the evidence. I speak for voiceless people, people whose voices are not heard anywhere. These people are suffering quietly but nobody spoke for them. (Grace)

Hmm, the role, you see, I think our role is to continue to get these facts from the ground and bring it up to the policy-makers, the people who are responsible for making policies so we can implement them, to ensure that all these things that we keep experiencing on the ground are dealt with. Other than that, people will forget how difficult issues are on the ground and entangled, issues such as economic empowerment, education, and health.

(Linda)

The above excerpts from Grace and Linda reveal that evidence gives bases for the advocacy. Evidence is one of the effective ways to support claims of the advocacy action and to ‘amplify’ the voice of the voiceless in society. Advocates, therefore, go to the grassroots and gather data as proof of the existence and the magnitude of the advocacy problem. Grace's further response below attests to this:

We get a lot of information from the ground, we are community-based, so we gather data, and information from the ground and make sure that the policies address these. Because we are with the people and we know what the issues are, all this information comes up and feeds into national policy. So, we talk as a community-based organisation letting them know the reality of the issues; it is not like the policy-makers who don't know what is happening and develop policies. (Grace)

Grace claims that women's rights advocates are grassroots workers who have first-hand information on the problems of the people they represent. The emphasis on the grassroots activities by advocates indicates that it is not only public servants and professionals named by Lipsky (1980) who act at the grassroots, but advocates are also grassroots community actors performing roles as policy entrepreneurs (Klugman, 2011). Here, Grace presents advocates as people who have a concrete basis for the policies they propose for

formulation or amendments or enforcement of implementation. Working at the grassroots: district and community levels, allows advocates to have primary data on reproductive health and violence against women issues. This contrasts with the policy-makers who are usually not in touch with the people though they are expected to have been also at the grassroots. Through this possession of evidence by advocates, the women's rights advocates give credence and justification to their role of representing the communities. There is also data indicating that without this role of women's rights advocates, policy-makers would be formulating policies that could not meet the needs of the people. Yvonne, therefore, referred to the issues around evidence as information politics in the extract below:

One major thing has been information politics, so these coalitions have information on issues, they get data on Sexual Reproductive Health and Rights issues they raise. We call it politics because it is about power. The one who has the information has the power to influence change. So that is one thing that most coalitions have or even in our organisation, we always buttress evidence-based advocacy. We just don't go out there and talk. (Yvonne)

From the discussion above, participants allude that control over data is political and it gives the one who has, power in the policy formulation and advocacy processes.

The importance of evidence is again revealed through a discussion by one of the participants that her organisation was set up primarily to research critical women's rights issues including violence against women and women's reproductive health to support advocacy actions.

Harriet: we felt that we needed more information to be able to push the issues of women because sometimes we made certain assertions about women's rights and people would ask for proof. So, we felt that we needed to have an organisation that would have research as one of its key focuses so that whatever we get will be useful, not only for us but for all organisations working on women's rights so we use the information to do advocacy.

Setting-up a whole organisation to pursue research and provide data for advocacy issues demonstrates the importance attached to evidence. Such research will have rigour and be detailed to provide evidence for advocacy and subsequently policy direction. According to Harriet, the data produced is not only used by her organisation but it is made available to all other women's rights groups who will need them. This indicates that women's rights advocates do not work in silos but they partner at various levels and share information at the country level. Without evidence, policy-makers accuse advocates of being sentimental and emotional about issues that may be non-existent. Linda opines that:

unfortunately policy-makers don't take the sentiments. They need the facts. Is this relevant nationwide? they ask. Sometimes we go to NACP, we start to talk, and they just want figures and percentages, and we sit down, and we are looking at them.

From Linda's submission evidence is a weapon/tool for advocates and its non-availability is a weapon for

the policy-maker. Advocates without evidence will not achieve their intended results. This is because policy-makers may trivialise the issues presented except they see proof that a considerable percentage of the population is suffering and therefore it makes economic sense to invest in the issues raised. It is of interest to note that some advocates accept that sometimes they are too sentimental and may not have gathered enough facts on the issues. According to Linda some advocates “tend to be too sentimental” on issues without facts. As provided by Emma and analysed under using media as a strategy in this chapter, some advocates may listen to the news and jump to advocate for it. Such positioning does not strengthen advocacy stands. The gathering of data is critical in advocacy in Ghana to get the attention of policy-makers and to frame the issues as planned.

Another participant, provided further insight in the extract below:

So we went to at least 2 districts per region and we had open meetings to talk about the issues and mind you, in this open meeting because we had the data, we were able to use that as the medium for discussion. (Linda).

Linda’s response indicates that data provide points of reference and also serve as the centre of discussions. The use of the data helps in creating a picture of the advocacy issues and aid in getting responses. Linda further gave an insight into the benefits of using information material in advocacy when she explained:

because we had the data, we were able to use that as the medium for discussion, so by the time we finished everybody said no, no, this one it is true, we must do something about it.

Grace indicates that evidence is not made up of data only but also the presentation of the people who are affected to tell their own stories.

...and also bring in some of the women who have benefited and use their stories as evidence of what the project has achieved. We use them to do the advocacy instead of us leading and to create the environment for them to consistently go back to the government and say you have not done what we requested.

This is an expression of Wessel’s (2018) position that qualitative inquiry uncovers aspects of social realities not available in quantitative inquiry. The narratives provided by the affected communities and target groups give in-depth information on the problem on the agenda. The evidence, therefore, gives a face to the advocacy issue presented.

Though many participants presented evidence as gathering primary data from the grassroots, or scientific research, evidence gathering could also be a desk review activity. Two of the women’s rights advocates, Emma and Yvonne, discussed this:

Emma: We need to use the law to influence policy, to influence legislation. And so, we do a lot of research looking at some of the gaps in some of the laws.

Yvonne: In most of the advocacy initiatives we start with either a desk review or even a field survey and then based on that we use the information as the reason why we are asking for this change to be made. So that is one, generating evidence is one of the major strategies.

Advocates review policy documents, implementation of policies, and news in the media, and through the reviews of documents obtain data for advocacy. Some advocates assert that the emphasis on the need for data gathering by advocates reveals that the government itself does not have adequate data on many reproductive health issues. Sandra, one of the participants, posited:

The documentation of cases is an issue. Who documents them? Somebody comes right now, recently Global Fund came, we couldn't even get statistics on gender-based violence to show them, and meanwhile we say people suffer gender-based violence. People don't have access to data so that is the key issue now. CHRAJ has set up an online information system for the marginalized; who reports? How are we reporting? Everything is at the national level. At the district, is there a representative that cases can go to? ...there are a lot of gaps in the system. (Sandra)

Linda however indicated that government has data, but it is not accessible by advocates. When explaining the importance of evidence, she said that:

...but are the platforms accessible to civil society because I told them a lot of times, the government has data, but it is not accessible to us, they are leading all sort of programmes but they keep the data to themselves and we can't access it. So sometimes, we also just hang in there. How do we know the number of people living with HIV in a particular district? It is very difficult for us to come up with concrete evidence to show. (Linda)

Their quotes also indicate that quantitative data is also useful in advocacy. Though the responses from Sandra and Linda seem different, both provide the same conclusion that data gathered by government agencies, even if available, may be at the national level only and not easily accessible. The data is not disaggregated into regions and districts. The collation of various forms of data at various levels is a challenge and hence accessing useful data, is difficult. But in a decentralised government system discussed by Mayhew (2003), it is expected that at the regional and district levels, data would be available and accessible (perhaps, this gap in accessing national level data influences and shapes the perception of the role played by women's rights advocacy groups in bringing up evidence from the grassroots for advocacy). So, Yvonne summarises on the issue of evidence in the quote below:

Advocacy groups also can provide evidence for example. Most policy institutions cannot access information and undertake research or data collection that can objectively influence policy. So, you have a lot of advocacy groups bringing evidence, and data to duty bearers. (Yvonne)

For Emma's organisation, they operate a legal aid centre, therefore they get data on the number of people who report cases on daily or weekly bases. The data give indications of what is happening in a particular reproductive health activity:

Sometimes we find out that because we have a legal aid centre people walk in and you see a trend so that draws our attention to the fact that people, more women are getting infected with HIV and AIDS, so that drew us, as far back as 2008, at that time, that drew us to research legal challenges facing women living with HIV and then we followed up, I think 2 years after that, with property rights of women living with HIV/AIDS. (Emma)

Emma again indicates that monitoring and evaluation of projects are also one of how data becomes available to women's rights advocacy groups. It is a normal part of the project management cycle of every organisation. Monitoring reports is also a data-gathering activity that provides feedback on projects and can be indicative of issues that need advocacy attention:

for us NGOs, there is always mid-term monitoring and evaluations we do, so all these monitoring and evaluations always inform us about what is happening within the project and how things are faring and then we go back to the drawing table. (Emma)

Apart from the above discussions on how data is obtained, as discussed earlier, there is one organisation that was solely set up because of the lack of data to produce research evidence. The organisation was set up to have as its primary focus, to engage in research to produce data on key gender issues including violence against women and women's reproductive health. The main role of this organisation in coalitions has, therefore, been to provide evidence:

I told you that one of the reasons for setting up the organisation was to do research, so in all our advocacy; media work, we have research as the backbone. If you take our work around violence against women, for example, it was based on national research we did, we used it to do our advocacy for the passage of the domestic violence law. We also used it to improve the response of government agencies, especially the police. It was out of that work, we engaged the police, and we did some training for them. In our gender norms and HIV research, we used those findings to advocate with the Ghana AIDS Commission at the time when they were doing the second national framework (NSP 2011-2015) so that was one of the tools that we used to mainstream gender in the national framework. (Harriet)

Harriet evidenced in the quote above the numerous benefits of research to the advocates. The data from participants show that depending on how the data tool for research was structured, research work has not only presented the problems, but it has given a lead to what the possible solutions should be. The response from Harriet below reveals this advantage of research:

It was because we had research findings people acknowledged that there was a problem. Also one of the key things was that we had then engaged the police. With all these people, the police, we had given them support, we had gotten UNFPA to support them to set up WAJU. (Harriet)

The excerpts above from Harriet explain that the establishment of WAJU (the Women and Juvenile Unit) of the Ghana Police Service, later called DOVVSU (Domestic Violence & Victim Support Unit) was as a result of a research on violence conducted by her organisation.

The above discussions make it clear that the need for research or evidence in the advocacy process is critical. It is a powerful tool to get demands met. Evidence is used to generate information materials and policy briefs for various advocacy activities and strategies. There are arguments that often research findings are simplified and gaps in research evidence are not thoroughly acknowledged in the advocacy process and that evidence-based framing can also include over-generalising from small-scale studies to present cases to policy-makers. Irrespective of this stand, women's rights advocates of this study indicate that evidence-based advocacy is important in framing advocacy issues to provide accurate policy direction.

6.2.1 Packaging and Presentation of the Evidence

Using information materials on policy

A participant discussed the use of information materials as a strategy of advocacy. The evidence generated is packaged to indicate that the problem being presented for policy formulation, enactment of a law, or enforcement of implementation exists. Ama, when speaking on the strategies of advocacy, stated “*The first strategy is using information materials on the policy issue and how the issues affect the people.*” The participant’s submission indicates clearly that the information materials are strategies to present evidence on how the policy issue affects the people. Information materials also serve as a point for discussion.

6.3 Presentation of Position Paper to Policy-makers

Position papers, also referred to by other participants of this study as policy briefs are drafted documents on the policy issues and the demands of the advocates. The participants of this study indicate that data gathered through research and case materials are analysed and key issues of advocacy developed into a position paper for policy-makers.

A participant of this study working with the UN provided insight on the use of policy briefs in advocacy. Augusta claimed that her organisation develops the briefs as a support to women's rights advocacy groups during the advocacy process. She stated “*we help to do the policy briefs, the research, do the analysis, and tease out the key things, we help with that.*”

Augusta’s statement evidenced support from other interested organisations in the advocacy process in Ghana. It also connotes augmenting the knowledge and skills of the advocates. If advocates do not have a particular skill needed, relevant UN organisations provide such technical support to the advocates. This also

confirms the role of the international community in the policy process of Ghana as conceptualized by Mukuru et al (2021) and Cherlet and Venot (2013). For a developing country like Ghana, its policies are largely influenced by international politics. From the excerpt above, it is established that research is critical in coming out with good policy briefs. The importance of the documents is the reason why a UN body supports the advocacy action in that respect.

6.4 Other Strategies Used in the Advocacy Process in Ghana

6.4.1 Meetings

Data from the study show that there are different kinds of meetings in advocacy. The difference comes with the target group and also what the meetings are intended to achieve. Largely, three types of meetings are discussed by participants of the study: interface meetings, meetings with policy-makers and duty bearers, and with the communities affected by the advocacy issue (s) under discussion. Sandra and Godfred discussed interface meetings in the extracts below.

We have also had a lot of interface meetings with the youth bringing together the youth and duty bearers, engaging them in reproductive health discussions, and documenting issues about their sexuality. (Sandra)

Godfred: For my organisation as an entity, we always want to play a role to bring community and duty bearers together even as we advocate improvement in the laws or policies or programmes. We also want the community to contribute, we want the duty bearers to contribute.

Interface meetings in the sense that, the meetings bring together duty bearers, policy-makers, and the communities at one venue to discuss the issues and proffer alternatives. According to Sandra, the women's rights advocate, who discussed advocacy on enhancing adolescents' access to sexual reproductive health and rights, interface meetings are platforms to document issues regarding the advocacy action. The documentation helps in clarifying the advocacy stands and provides first-hand information to duty bearers on preferred alternatives. Community engagement is presented by Sandra as an important aspect of advocacy. This is in tandem with the discussion on the meaning of advocacy in chapter four which highlighted the level of influence by the various stakeholders and the concept of representation highlighting the importance of the involvement of the beneficiaries of advocacy actions in the advocacy process. According to Godfred, the interface meetings provide the opportunity for duty bearers and beneficiary communities to contribute to the advocacy issue.

Another type of meetings discussed by participants is consultative meetings. Participants provided that these meetings are held with people who are known or perceived to be directly affected by the advocacy issues being pushed. The participants assert that consultative meetings have, as their objectives, to gather support,

build momentum and get stakeholders to acquire first-hand information on the advocacy actions. Participants provided that such meetings are also organised to get inputs from the affected communities as discussed also under interface meetings and to get them to join the movement for the advocacy. Grace's extract below expands on the point.

People use consultative meetings and use the people who are suffering, and affected by the issues, directing them to lead the advocacy. For example, if you are talking about young people infected and affected with HIV, you want the young people themselves to come and lead. (Grace)

Grace's response illustrates that such meetings provide the platform for the communities affected by the issues to join the advocacy action. Such meetings help in presenting a face to the advocacy because, in the meetings, the people who are affected themselves are present to tell their stories. The meetings could also help shape the discussions and make them focused as the affected communities/segments experience it and hence proffer solutions they think they need. Grace, when discussing immunisation, highlighted the importance of beneficiary involvement:

we got a lot of mothers to see that the resources and immunisation is their right. So, we mobilised all those people as our allies then we brought in the media.

According to Grace, the meetings help to educate the affected communities and segments to know what their rights are so they can demand it and thereby effect a cultural change by building the capacity of affected communities to find their voices. Knowing one's rights positions the person to demand the availability of resources and to demand that duty bearers deliver services. This resonates with one of the goals of advocacy in Ghana discussed in chapter four, the promotion of culture and the idea of rights and justice. Kyereho, a policy-maker, also provided that women's rights advocacy groups 'participate in dialogues, *consultative meetings and submit memoranda on key policy issues for consideration of the Ministry*' she works at.

Another participant, Emma, indicated that consultative meetings provide a platform for the people affected by the advocacy issues to proffer solutions. The extract below evidences her stand:

Emma: One thing that we do these days, is not for us alone to come up with a solution but for the community to also make an input. We had an issue. We were training women living with HIV. People who didn't have the disease were telling others that we were working with people with HIV. Because of this, we were not getting the numbers, because the people living with HIV heard that the community knows they are positive, and because of stigma issues the numbers were not showing up. We were worried because that was why we were doing the project.

However, Emma indicates stigma as a challenge in dealing with vulnerable groups and this hampers the process of representation in the advocacy process as target beneficiaries stopped participating in their activities.

The excerpt below from another participant again confirms the same idea:

Godfred: So, for advocacy, you should not always be targeting the duty bearer, the one who is taking the decision, you should be able to also bring on board the one that policy benefits so they appreciate it and also bring them closer to have some kind of consensus and mutual understanding of whatever benefit will come out of the policy or even a programme.

Participants of this study indicated that Consultative meetings are not held with communities or those affected by the advocacy issues alone, but with all stakeholders of the advocacy including duty bearers, what Lipsky (1980) refers to as street-level bureaucrats (those in charge of the delivery of services or ensuring that policies are implemented). As part of an advocacy activity on giving Post-Exposure Prophylaxis (PEP) to rape victims, Sandra said that the relevant ministry asked her “*do you have money for a stakeholders meeting? I said ‘yes’, they said, organise stakeholder meetings.*” All the doctors in the districts we were working in came there to pledge their support to the programme and that is how we started giving PEP in Ghana. The meeting with the implementers of the policy, in this case, the doctors, helped in rolling out the implementation of the PEP for raped victims.

Participants discussed that targets of consultative meetings could also be organisational partners or even relevant ministries and agencies. This is illustrated in the excerpt from Grace, “*We started organising consultative meetings, we brought Civil Society together.*” In this instance, the consultative meetings are the beginning of movement building which is likely to produce a coalition for the advocacy. Augusta, a participant working with a UN organisation, also provided the same insight in the excerpt below however the participation of her organisation brought the international perspective to discussions:

Augusta: ...we help with that and then special consultation sessions. Sometimes the agency was part. Our representatives at such meetings sometimes brought the international angle to bear on discussions and how important it applied to the national discourse.

The participation of different groups and organisations in consultative meetings helps in bringing different angles and different opinions to bear on the advocacy issues.

Two participants also discussed meetings with policy-makers as crucial in advocacy meetings, if not the most important. It is a major activity to get the attention of policy-makers to act. Sandra, providing information on advocacy geared towards the provision of PEP to rape victims stated that:

we went to see the Regional Director of Health, I had to do a presentation. NACP was then charged to develop the guidelines, so they started with the guidelines.

Another participant also confirmed the importance of meeting with policy/law-makers:

Then we were engaging parliament. Once it went to parliament, it was given to the select committee, ... when we tell the members of parliament, we know they don't have time, and ask for an hour and a half meeting to consider the issues, we need to buy them lunch. When they were considering it (the draft Domestic Violence Bill), we would send people there to do a presentation just like they do for most laws. (Harriet)

The insight from Harriet's submission is that lunch meetings help a lot. Parliamentarians, and by extension, many policy-makers, are very busy people. Getting their attention for a meeting could be a difficult task. Their lunchtime may be the only available opportunity to engage them.

Advocates also use various meetings they attend (such meetings may not be planned advocacy meetings) and represent their groups to advocate on issues that are in the public space and gather support. Usually, the participants of such meetings would have included policy-makers, duty bearers, or people that advocates think policy-makers listen to when they talk. Linda, one of the participants is quoted below on such advocacy strategy:

Linda: So far, I will say the meetings, because it just happens to be meetings that you know people who are present are people when they talk people listen, like the leadership of the CCM and the Ghana AIDS Commission. when they talk people listen. In terms of human rights issues, CHRAC is on some of these platforms, so they pick up some of these issues and work on them.

Although the above meeting strategy may look spontaneous, advocates plan their presentations at such meetings to have an effect and to win champions to support their advocacy stands.

The above discussions on meeting as a strategy suggest an open policy environment that enables the meeting of beneficiaries with policy-makers and duty bearers in decision-making on key issues that affect them. The role of women's rights advocates as convenors of these meetings bridges the communities affected and the policy-makers and duty bearers as they perform their various roles as policy entrepreneurs. Though there seem to be different types of meetings, interface meetings, consultative meetings, and meetings with policy-makers, they are keenly discussed as critical for successful advocacy.

6.4.2 Media advocacy

Five participants revealed that using the media is one of the key strategies in advocacy. The media as the fourth arm of government is involved in advocacy to help keep the issues in the public space. As reviewed in the literature, media coverage draws attention to problems. It also influences agenda-setting for policy-makers and the public (McKeever, 2012). When the issues are kept in the public space, it helps to create

awareness and put pressure on policy-makers to act. Idris and Aseda, two women's rights advocates, discussed the use of media in advocacy:

Idris: We also used the media a lot. They interviewed the ministers. "Are you aware that this is the situation? If you are aware, what have you done or what are you going to do? That is the issue of accountability on the part of the state or the service providers.

We have media advocacy for ART. We do use the media for our ART caravan with the Ghana AIDS Commission. So we go with the media to the ante-natal centres of the clinics and hospitals. I share my experience as living with HIV having delivered negative children because I take my ARVs. I have been doing this for 2 years. (Aseda)

Policy-makers are an elite group and hence reaching them can be difficult. The media, however, by the nature of their work, can reach them with more ease than many people. Their role, therefore, makes policy-makers aware of the advocacy issue and keeps it on the agenda. Idris asserts that the use of media helps in making policy-makers accountable to the citizens. If a policy-maker ignores the media reports, the public mounts pressure to demand accountability. Yvonne, the women's rights advocate who discussed the policy audit that led to the Ghana AIDS Commission ACT, corroborates the need for media in the advocacy process:

The other thing is using a lot of media; collaborating with media to raise awareness on issues. Some may call it media advocacy. So, you don't target policy-makers directly, but you target the media. If you get the media to understand the issues, to own your issues then they can carry it out and you get policy-makers to respond to them. (Yvonne)

Advocates and the media know that policy-makers do not want to be presented in the media as irresponsible. They would not want bad news about their persons or their outfits. The media is therefore used in getting the message across to policy-makers because news, reports, and articles in the media are circulated widely. This makes policy-makers attentive to the issues. Getting the media to own the issues is critical according to Yvonne. Owning implies, a 'buy-in into the advocacy issues. Another gender advocate, corroborated the use of media in advocacy. She explained:

Fortunately when we do the programmes we arrange media encounters for the media to cover our programmes so policy-makers will know. (Ama)

In Ama's account, the media provides coverage for advocacy activities for news and other bulletins of the media house. Emma, the women's rights advocate, who discussed the formation of the Sister's Keepers and Domestic Violence Coalition during the era of serial killing of women in Ghana, also provided that "*It was a whole decade of doing a lot of advocacies. With media, we were going to the ground itself.*" Getting to the ground implies bringing up the advocacy issues just as it is, from where the issues affect the people. It implies an unadulterated presentation of the advocacy issues. The media, apart from interviews with policy-

makers, could also interview the affected communities, the advocates, and other stakeholders. The participants of this research indicated that radio talks, TV interviews, articles in the print media, and press releases are all some of the media strategies used. The excerpts below from Harriet and Idris illustrate the different media approaches used by advocates:

Harriet: We were writing articles in the newspapers. We were going on the radio and TV. All these were just to keep the issue in the public space.

Idris: We used radio discussions, TV, and press releases, usually I do a press release and in no time, they are interviewing the Ministers.

The excerpts above show the different types of media active in Ghana's advocacy. Both print and electronic media are available for the use of advocates.

In contrast, Emma is of the view that media is not always beneficial to the advocate. Sometimes, advocates hear from radio or TV stations or read stories in the media and jump into advocacy without any research:

This is sometimes the bane. People just hear on the radio, through the media, and take up arms without due diligence, meaning that you have your data, your facts, and the alternative solution to the problem so when you meet duty bearers, then you can present it to them. And then you take it up. (Emma)

Apart from media stories, an advocate is expected to have her facts right, pay due diligence, and research alternatives before approaching duty bearers or policy-makers.

6.4.3 Demonstration

Two women's rights advocacy group leaders discussed demonstration as one of the strategies for advocacy. A demonstration is an outdoor event where advocates walk on the streets with placards with messages of the advocacy inscribed on them. According to Grace, demonstration as an activity is usually followed by a presentation of a position paper to the relevant ministries. She indicated that demonstration was one of the strategies used in their advocacy for immunisation.

We started our advocacy, even with just a little demonstration before we presented a paper to the Minister for Health to ensure that Civil Society and women are part of the immunisation agenda and the NGOs should be resourced to go to hard-to-reach communities and mobilise the women. (Grace)

Godfred however discussed that demonstration is used as a last resort. When advocates have done a lot of work but still lack an audience with policy-makers, they take to the streets:

You have been demanding, you have been dialoguing, you have been doing the lobbying and it is not working, get the people onto the streets. Yes, that is the more militant way, but unfortunately for us, in Ghana, we have stopped the militant advocacy.

But Grace's excerpt above indicates that demonstration was a strategy that began the advocacy. It was used as a platform to get the Minister to present a paper to him. These two uses of demonstration indicate that strategies for advocacy do not have a sequence, one organisation may decide to use a strategy at the beginning of the advocacy and another organisation or advocacy group may use the same strategy at the end or as part of a set of strategies. For Godfred, demonstration seems to be a last resort and a strategy perceived to mount pressure.

6.4.4 Lobbying

Participants of this study referred to lobbying as a strategy that usually targets specific policy-makers on advocacy issues in private meetings and hence called them "behind the scenes strategies". In the quote below, Godfred regards lobbying as the best advocacy strategy:

I always say that people think lobbying is another advocacy. No, lobbying is an advocacy strategy, and it has been the best form of advocacy and dialogue. But you should be able to adopt a particular strategy that will fit at a particular point in time.

Godfred, after asserting that lobbying is the best advocacy strategy, suggests that it could not be prescribed for all situations and that different advocacy actions and different situations demand suitable approaches/strategies. The response from Ikem (the women's rights advocate who discussed the training of middle-level professionals to provide abortion services and sex education in schools) below raises critical issues on lobbying and corroborates Godfred's assertion that lobbying is one of the best advocacy strategies. Usually, the policy-maker being lobbied will be either personally known by the advocate or the advocate has been introduced to the policy-maker by someone close to him/her. When there is a personal touch or friendship between the advocate and the policy-maker, it becomes easier to reach the policy-maker:

One of the strongest advocacy strategies ...is lobbying. Whether you like it or not, lobbying is part of it. Two, you can develop your tactics, if someone is your 'body body' (friend), it is easier to talk to that person, he will not push you away. He will listen to you, but the secret with lobbying is that, try as much as possible to use unconventional ways to get the person to your side, and they are more relaxed to talk to you. (Ikem)

According to Ikem, because of the busy schedules and social status of policy-makers, a lobbyist must have strong connections with the policy-maker to book an appointment and get a quick response for lobbying that yields results. This corroborates the assertion of Ball and Exley (2010) that there is a degree of connection between policy networks and other policy actors and the level of connections influence the level of power. So Ikem calls it "*unconventional ways to get to policy-makers*", but direct access to the policy-maker could yield results within a short period rather than booking a formal appointment which may take months and even years to get the attention of the policy-maker.

For the above reasons, the use of ‘gatekeepers’ in advocacy has been widely adopted specially to help with lobbying. Gatekeepers of advocates are the people who are usually close to the policy-makers Liu, X. (2018). They include close associates, spouses, parents and siblings, friends, and even their trusted domestic staff. Advocates contact these close people to the policy-maker and use them as “gates” to the policy-maker. Making friends with policy-makers is an essential ‘ingredient’ for advocacy. Ikem again explained that:

Apart from using all the evidence for action and the statistics to display, meeting the right people is very important. Before you go to medical school, if the head is not your friend, he will treat you officially, and he would tell you that this is what we do, we don’t need that. But if he is your friend, you should be able to use that. So try to build trust and I think it is important, very, very important. (Ikem)

Emma, presenting lobbying as negotiation behind the scenes, said:

Negotiation behind the scenes. Let people understand and buy into your agenda. Be very transparent to let them know what the issues are and convince them to also see them as issues that need advocacy. If you do that and the people are aware of the issues you see them coming to join the advocacy.

Ikem stressed that trust is necessary to have successful lobbying. Emma also mentioned transparency as key to ensuring successful lobbying. These attributes are being brought forward because lobbying is a strategy that depends largely on friendship or social networking and hence it is important to ensure that the friendship and connections will not be abused.

Sandra, the participant who discussed the introduction of post-exposure prophylaxes (PEP), refers to lobbying as “whom you know linkages”. If the advocate knows the policy-maker or someone who knows the policy-maker, it makes access to the decision-making realm easier. Her extract below expands on her stand:

The first tactic is whom you know linkages. So, somebody will link you up first then you start your lobbying to get to know the people before you try to talk to them, and when they agree that’s ok, you can meet them. So, you see linkages, lobbying up and down, going up and down, that is all the strategies. If I want to get to something, I start looking at the people I know and make phone calls. In our coalition, if we have an issue, we ask, so who is the person that we need to target, to channel this through and we start getting somebody who knows him/her. So that is how it is done. (Sandra)

The discussions of the participants of this research indicate that advocates lobby many policy-makers behind the scenes before a major meeting on the advocacy issue. When properly done, it implies that before the meeting, many policy-makers, on their levels, have agreed on the issues already (behind the scenes). A meeting thus becomes an affirmation of the decisions and conclusions already achieved during lobbying. Before meetings with policy-makers, consultative meetings with interest groups would have been organised.

6.5 Conclusion

This chapter has discussed in detail various framings used by advocates in Ghana to get their advocacy messages on the agenda for policy formulation and implementation. The data provided indicates the awareness of advocates that framing affects the acceptability of their messages and hence it is strategically used to illicit needed responses as found by Farrer et al (2015). Though literature does not abound on culture and framing, this research indicates that culture affects both framings and the responses from policy-makers and duty bearers. Gender, which is considered an inclusive term/framing, is therefore heavily used by advocates against a term/concept like feminist, which is considered non-Ghanaian. Though literature also indicates that gender is for both sexes, there is no evidence of such profound strategic use in literature as it is done by women's rights advocacy groups in Ghana. It enables the navigation of a patriarchal culture and a policy realm dominated by men to achieve policy goals when windows of opportunities open (FAO, 2012). It is used to arrive at specific framings such as reproductive health, child health, rights, and violence against women. This gives credence to the assertion that gender contributes to constructing inequality as women's rights advocates must strategically go around gender in order to get advocacy demands on the agenda (Gordon 2013). One key concern is to what extent do the compromises using gender affect agenda-setting?

Again, in this chapter evidence has been discussed as a demand by policy-makers from women's rights advocacy groups as basis for legitimacy for their advocacy actions. The data provided emphasised that evidence is key in successful advocacy and that the one who has evidence/information has power in the policy-making processes. With this, advocates are involved in bringing evidence from the grassroots as they emphasise their representational role of their target groups. Women's rights advocates strategically claim legitimacy through the provision of evidence from the grassroots to the policy-makers thereby ensuring a bottom-up approach to policy-making and implementation (Lipsky, 1980). The analysis indicated that participants perceive the control of evidence as 'infopolitics'. The one who has evidence has power. The data presented by participants indicate that there is inadequate access to government level data on all levels - national, regional and district. Perhaps, this is the driving force for women's rights advocates to generate evidence for their advocacy actions.

The chapter also discussed access strategies such as meetings, lobbying, demonstrations, and the role of the mass media in the policy-making process. The media creates awareness of advocacy issues and are a 'pressure' on policy-makers and duty bearers to act. The media also helps in negotiating access through their publications for policy-makers to engage on advocacy issues. These roles of the media depict a stronger

policy actor than Kingdon (1984) depicts in his study of the US policy-making, because their roles in policy-making in Ghana demonstrate that they are crucial in ensuring that issues pursued by advocates are sustained in the public discussions and policy-makers give attention to them.

The next chapter discusses coalition building as a strategy for strengthening the voices for advocacy and its benefits to the advocacy processes. It will analyse the relationships between the various coalition members and various actors of the advocacy processes. The chapter also discusses funding for advocacy.

CHAPTER 7: THE DYNAMICS OF COALITION BUILDING AND FUNDING IN THE GHANAIAN ADVOCACY CONTEXT

7.0 Introduction

This chapter is the third of the data analysis chapters. In this chapter, the discussions on coalition building; nature and size, benefits of coalition building in the advocacy process, dynamics, and implications are analysed. The size of a coalition in the policy subsystem is one of the key elements of the ACF. In the first section of this chapter, the nature and size of the coalitions that work on women's reproductive health and rights are discussed, focusing on the events that lead to coalition formation, coalition growth and maintenance, and the vision and mission of the advocacy coalitions.

Again, in the first section, the relevance of coalition building to the advocacy process is analysed. The discussion on relevance centres around the advantages of coalition building. The ACF discussed in chapter three demonstrates that resources are key elements of advocacy coalitions and have an impact on policy outputs and outcomes. The key resources discussed in this chapter are huge numbers of people for advocacy, funds, advocacy experience, wider geographical reach, professional skills, and access to policy-makers. There is also an analysis of the effects of smaller organisations deciding to pursue advocacy actions alone and how such decision affects the outcome of the policy change they pursued.

Drawing from key elements of the ACF, the chapter discusses the behaviour of women's rights advocacy groups as actors in the policy-making process. The discussion of the dynamics of the relationships between women's rights advocacy groups, the donor community, and policy actors includes key issues on what influences the behaviour of coalition members, learning, the power struggle for relevance, resources, and dominance, which coalitions do policy actors prefer to work with and why the preferences. The analysis highlights the power domain of advocacy and its relevance in either taking advantage of windows of opportunity or as advocates creating the opportunities for policy issues on women's reproductive health to be considered by policy-makers.

It is in the second section of this chapter that the influence of the international community on funding for advocacy activities is extensively discussed. The analysis highlights how the donor community, largely international bodies; the UN, bilateral relations organisations, and large funding entities from the Global North could affect what issues of reproductive health or gender and right get to the agenda. This indicates

the importance of the ACF in considering that the international environment affects policy-making in developing countries like Ghana as the donor community pursues their own interest through advocacy actions they fund. The analysis then indicates that the international community's actions and inactions influence the items that become part of the agenda and their funding could sustain it or remove it from being an issue for policy attention. Their actions also impact on the dynamics in the coalition especially the behaviour of coalition members. However, women's rights advocates, as policy entrepreneurs, still innovatively employ their skills and resources to ensure that they are also able to pursue their advocacy interests. The chapter concludes with the funding priorities of the women's rights advocacy groups and their importance in the advocacy process in Ghana. This chapter answers the research question; from the perspectives and experiences of women's rights advocacy groups and policy-makers, how do resources, relationships and context influence the advocacy process and impact?

7.1 Coalition Building

7.1.1 Nature and Size of Coalitions in Ghana

As theorised by Cullerton et al. (2018), this study found support for the claim that advocacy groups use coalition building as a major strategy to achieve advocacy outcomes. Coalition building helps to gather both human and material resources and strengthen the voice of the advocacy group(s). The data provided by the sampled participants indicate that in some advocacy circles in Ghana, coalitions are called movements and in others, they are called networks. Although coalitions, movements, and networks are not quite the same (whereas a coalition is a more directly related and formulated strategic alliance, a movement is more diffused where members may not directly work together), a coalition is a form of network, and it is orientated to political ends and means but the notion of a network could be applied to much more than coalitions. It is evident through the data that advocates do not perceive a sharp difference as some coalitions join networks and network members join coalitions. However, the data provided by participants in this study indicate two main types of coalitions in the advocacy process in Ghana: established coalitions (networks) that have, to some extent, a permanent nature and are registered as an organisation with registered members who pay dues. Membership is usually made of organisations, but some individuals register as members and a loose coalition where members come together for a particular advocacy activity and disperse after that. This is illustrated in the excerpt below from a women's rights advocate, Grace stated in the extract below when in the discussing of coalitions that her organisation was part of coalitions:

We are part of coalitions. NETRIGHT is a women's coalition, Wildaf, Child right. Non-State Actors is an advocacy group. SWAA is a network.

Sandra, another participant, also indicated that her organisation is a member of the “*Alliance for Reproductive Health and Rights*”. As indicated earlier, some coalitions are established as networks. Godfred discussed the nature of his group in the excerpt below:

My organisation by nature is a network, so there are certain projects that we form a coalition or consortium to implement. We have joined hands with Abantu, we have joined hands with the gender centre, with FIDA, the Hunger Project, and the artisan association.

It is interesting to note that Godfred’s organisation, which is an established network (with organisational members), forms coalitions with other organisations to implement selected advocacy actions. NETRIGHT (Network for Women’s Rights) referred to by Grace as a coalition is a registered network of women’s rights advocacy groups of about 83 organisational members (NETRIGHT, 2017). The main mission of NETRIGHT is “to promote women’s rights in Ghana through the critical analysis of gender dimensions of national processes and policies and advocate for policy change” (NETRIGHT, 2017). Wildaf, is also a network of women’s groups. Most of their leaders are female lawyers. The mission of Wildaf is to promote gender equality and development by advocating the rights of women and increasing their participation in decision- making in Ghana using law as a tool” (Wildaf, 2019). It has 25 active organisational members and ten (10) individual members (Wildaf, 2019). Non-state actors are a new coalition of all non-state actors which has been formed in Ghana and Sandra indicated that membership consists of both “*national and international organisations*”. SWAA is a women’s advocacy group with 49 organisational members, and it also has individual members. The main aim of SWAA is to advocate for women and their reproductive health especially HIV and AIDS (SWAA, 2017).

Yvonne also discussed the Coalition of NGOs in health and provides insight into the nature of the Coalition in the quote below:

Yvonne: In our just ended work with the Coalition of NGOs in Health, what we realised was that it is a well-structured coalition but in terms of implementation a lot of directives come from the secretariat of the coalition. So, they go ahead to seek funding, write proposals, pick on government issues and then speak to them so it is one secretariat headed by the Chairperson.

The description of the coalition of NGOs in Health above indicates that the coalition is established with defined members, and it has a secretariat. As a permanent coalition, organisations with similar visions could join. This could then fit the definition of a network as outlined at the beginning of this chapter by Grace and Godfred. This confirms the earlier claim that women’s rights advocacy groups do not distinguish between coalitions and networks. The names are chosen by the groups to define their existence.

However, as evidenced below, Godfred indicates the second nature of coalitions which is also very common and usually seen in national-level advocacy. When there is an issue on reproductive health or violence against women, women's rights advocacy groups would consult other organisations with similar visions and collaborate to execute a particular advocacy agenda. Such organisations may not join and register a permanent coalition or network, but all the members of the coalition work together if the advocacy demands are not met by the government. After the advocacy demands have been met, such coalitions usually dissolve naturally. The groups may come together again when there is another advocacy issue:

The Domestic Violence (DV) Coalition, for instance, they were so much interested in pushing for the DV Act to be passed. After pushing for the ACT to be passed, 11 years ago, they slumber. So, you could see that the DV Coalition is not strong now. You could see that in the past 2, or 3 years, there have been a lot of domestic violence cases, but their voice is dead. (Godfred)

The quote above highlights challenges for women's rights advocacy coalitions in terms of effectiveness. On the one hand, the Domestic Violence Coalition was effective in securing legal change by being so focused on its demands. However, once the legal change was achieved, it seemed it has struggled to broaden its claims to address implementation challenges and maintain the momentum. Another participant, Emma, also discussed the Domestic Violence Coalition as presented in the quote below:

The Domestic Violence Coalition, we were very active. At that time, the Domestic Violence Law was being advocated for, so we joined, worked together, and travelled to various regions, talking about domestic violence, its impact, and why we are calling for a law. Even the Ministry of Women at that time would reach us to join the media advocacy programmes, so we were very much active in the Domestic Violence Coalition.

The quote above shows the effectiveness of the Coalition is indicated by the fact that even the Ministry of Women, Gender, and social protection (a policy-maker) recognised its work and partnered for further engagements. This extract from Emma evidences a focused and effective advocacy around legal change. It does not however negate Godfred's assertion of a reduction in momentum for advocacy and issues emanating from the coalition's work. Emma indicates a strong focus during the advocacy process which Godfred also acknowledged but he provides additional data on the struggle to maintain such focus once the legal change is achieved. Harriet also corroborated Emma's information that the advocacy for Domestic Violence bill was done by a coalition:

The Domestic Violence advocacy was with a coalition. When we did the research and came up with the publication, one of the key findings was that we needed a comprehensive law to deal with violence against women. So, from day one, that was a key thing.

According to Harriet, forming a coalition was a key issue from the start of the domestic violence advocacy. In discussing the distinction between the coalition that worked on domestic violence and the networks

discussed as NETRIGHT and Wildaf, data from the sampled participants indicate that those registered as networks stay around for longer. Idris also provides insight into other Coalitions; the Universal Access to Health Campaign Coalition and the MDGs platform, which is also a coalition of organisations working on the Millennium Development Goals (MDGs):

We had the MDGs platform and strategically what we did was all the NGOs that were into health came together to join the health platform and then we were promoting the health MDGs, ... so there was a coalition known as the MDGs platform. And then after that, the Universal Access to Health Care campaign was a coalition of NGOs. We had a Coalition of NGOs in health, ... So, most NGOs are into coalitions.

Idris indicates that most NGOs join coalitions. He further recounts the experiences of the universal access to health campaign coalition in the extract:

After that, we also have the Universal Access to healthcare campaign coalition. It was a coalition of NGOs that advocated for Ghana to move to universal access to healthcare. You know the National Health Insurance was limited, so we advocated that government should open it up and make healthcare free at the point of use. So, there was a coalition of NGOs that came together to push for universal access.

This data from Idris highlights the effectiveness and the extensive nature of the work of coalitions. He raises an issue about linking up specific campaigns (around reproductive health) with broader health campaigns around universal health needs and health financing to have a bigger impact. There was evidence in this research that women's rights advocacy groups saw it as their role to work hard to ensure that the scheme widely covered many ailments to alleviate the health burden on women as discussed under 4.3.6 in chapter four. This indicates advocacy groups are helping to formulate policies and reforms in some detail in the Ghanaian context. He indicated in the extract below that people and organisations join coalitions when they see the building of a strong “base” so the movement in action also adds to its membership:

Sometimes we tried to engage the National Health Insurance Authority and sometimes we meet some people from the Ghana Health Service and the National Health Insurance Authority one on one and then we continued building our base, more people started coming. (Idris)

The above provides more evidence for the importance of engaging with policy-makers. Emma provided information on a coalition that was formed in the early 1990s called Sisters’ Keepers. According to her, the coalition was a response to the serial killing of women in Ghana. In those days, many of the killings were framed as spousal or domestic violence-related:

That time, what is called the Sisters’ Keepers, so the women groups formed a coalition to mainly advocating against these killings and to get police response because they were not arresting any murderer and we were seeing more and more women being killed all the time. (Emma)

The Sisters' Keepers aimed to advocate against serial killings of women and the seeming unresponsiveness of policy-makers and duty-bearers to ensure perpetrators were arrested and made to face the law.

Irrespective of the evidence available that many women's groups join coalitions, one participant however stated that, her organisation is not a member of a coalition but they work with coalitions to achieve particular aims.

Yvonne: Yes, we are not formal members of any coalition, but we work a lot with coalitions though we are not registered members of any coalition. We have partnerships. One of our recent reproductive health projects that ended just last December, we worked with the Coalition of NGOs in Health for the past 3 years on the project. We make it formal in terms of having an MOU.

Yvonne had earlier on discussed her group's involvement with the experiences of the universal access to health campaign coalition for a broader National Health Insurance Scheme. Stating that they do not belong to any formal coalitions means that they are not registered with the coalitions which are established networks. They prefer to act more independently and, on an issue, participate in loose coalition activities and work in implementing projects and advocacy actions.

7.1.2 The Size of Advocacy Coalitions

The data gathered indicates that advocacy coalitions could consist of more than 30 groups or organisations. Two of the participants in this study took the view that the larger the group, the louder and stronger the voice. Numbers in advocacy were, for many participants in this study, associated with... critical to exert force on policy-makers to ensure advocacy demands are delivered.

A participant indicated there could be 30 organisations in the advocacy coalition.

At least 30, some of the organisations that came on board, at the time, were not even working on violence but because we opened the floor and said, let us come together. Of course, we had individual members who were not aligned to any organisation. (Harriet)

NETRIGHT is a network of women's rights advocacy groups of about 87 organisational members. All these members are registered as full members of the network. They pursue their organisational agenda but also pursue joint agendas if there are women's rights advocacy issues that need to be pursued. Wildaf has 25 active organisational members and ten (10) individual members (<https://wildaf-ghana.org/network-members/>). Responses discussed above also demonstrate that the membership of a coalition can also include coalitions. In this case, then, the coalition could have many organisations, counting over 100. The above argument is premised on the fact that in the domestic violence coalition, Wildaf was a member. Then it implies that Wildaf's presence in the coalition brought on board 25 organisational members and ten

individual members. SWAA Ghana also joined the Domestic violence coalition at a point, bringing on board 47 members. There are therefore no strict rules on how many organisations should form a coalition or what the nature of the organisations should be. The only criterion is that the organisation should have an interest in the ongoing advocacy action. Individuals could also join the coalitions. Participants assert that many of the members of the coalitions are usually local groups/organisations:

Grace: Most of the time they are local NGOs, they are associations, individuals, women's groups, and media are part of it. Maybe at the international level, we have Sexual Reproductive Health and Rights coalitions, but in Ghana, we don't have international NGOs. International NGOs sometimes participate in such coalition meetings like in NETRIGHT, but mostly in Ghana, it is local NGOs.

Linda also claimed in the extract below that:

Most of the networks are made up of NGOs and the NGOs work with the people so we get to know the issues, whether that will help us is another issue because our allies are all NGOs.

The participant doubts if "all local" membership is helpful. She however provides that a new coalition that has been set up in Ghana has a good representation of international NGOs and development partners; and that the coalition, which Grace also refers to as an advocacy group, everything non-state:

But for the first time, with the non-state actors, these are made of entities that are truly non-state, non-governmental, so we have entities like developmental partners, entities like the private sector, everything that is non-state are part of it and I think that is the uniqueness of this one. It is too early for us to start saying anything now, but we know it is starting well.

From the above, the non-state advocacy group is perceived to have an advantage that accrues to its membership and goal because it has an international membership. A participant whose organisation is also a member of the non-state actors, intimated:

Not that I have seen from the CSOs front, but for non-state actors, everybody is part of it. Decision-making is very participatory, even now we have platforms so we hold discussions, and we say members should vote so we even count the votes. For now, we are working together. (Sandra)

It is perhaps related to the need to have good links with non-state actors beyond local NGO links. From Linda and Sandra, who are members of the Non-State Actors advocacy group, the group has started well because decision-making is broader. the new coalition will help boost advocacy in Ghana and will showcase something different in terms of advocacy.

Nature of Coalition/Network

Below is a table of the coalitions and networks mentioned in the discussion above and their nature.

No.	Nature of Coalition/Network
1	A women's group including women working in various fields
2	A lawyers-led group
3	A child rights organisation
4	A group of organisations with membership open to all non-state organisations
5	A coalition with a focus on Violence Against women
6	Society for Women who advocate on HIV and Sexual Reproductive Health and Rights
7	A women's group that works on women and politics
8	Coalition of health-related NGOs
9	Universal Access to Health Campaign coalition
10	MDGs platform
11	Women's movement that worked on the serial killings of women

7.1.3 The Relevance of Coalition Building in the Advocacy Process

Women's rights advocacy groups enumerate importance of coalitions in the advocacy process. The first importance of coalitions to women's rights advocacy groups in Ghana, according to the research participants, is that it brings many people to join the advocacy activity and hence provides a stronger voice to be heard by policy-makers. Harriet attests to this below:

One organisation cannot do advocacy and make it work, you need collaboration of several organisations so that you will have the numbers to be able to make your advocacy more efficient and so that is how we set up this organisation.

This relates to pooling resources as well as being more effective. *Linda also stated:*

You know when it comes to advocacy, especially as the advocacy goes up and it is getting to decision-makers, you need people.

From the extract, the participant emphasised the importance of links with policy-makers in the advocacy process. The two statements above could mean that some organisations can start an advocacy activity alone but as the advocacy gathers momentum and it gets closer to policy-makers, the organisation would need to

seek support from other organisations, especially to get many people to join the advocacy action, gather resources and be formidable for policy-makers to reckon with. Many people mean a stronger voice that could be heard by policy-makers. Emma and Linda expressed this in the excerpts below:

And also, when we have a bigger voice, we know we can attract attention, so it is not just one small NGO somewhere that is making, what they term ‘noise’ about particular issues, about reproductive health rights. We are all joined together, and the message is uniform. (Emma)

The importance of coalition is that for any advocacy to work, you need to be able to get people or organisations who have the same vision about whatever you are trying to push. People must believe in what you are doing. The more people you have the louder the voice. One voice does not carry far like that of a whole crowd. That is why for instance, it is easier when you have people; when there is a crowd. Sometimes crowds can be difficult to manage but at the same time, you can use them. You cannot have effective advocacy without having the right allies to join. (Linda)

A small NGO doing advocacy alone will not attract attention because the voice will be weak and because they have limited resources. When many organisations come together to speak on the same issue, the issue is heard much quicker. The united strong voice also becomes a force to reckon with and policy-makers give attention to the voice, or else the talks are perceived as ‘noise’ and it is ineffective. When advocacy messages happen to differ from one organisation to another, it makes the message fragmented. A respondent further said:

Grace: You know advocacy is numbers and, in the coalition, you have those numbers and different expertise. Advocacy needs a strong voice and a coalition provides this. It is important. Without that you cannot make a change, you will just be making noise but when you get the numbers, you see people running, and quickly you can make a change.

Participants took the view that larger numbers involved in advocacy are important for effectiveness. Although the Domestic Violence Coalition took 10 years to get the Domestic Violence Law passed, perhaps the impact is improved through numbers, but the timeliness of impact depends on broader political factors and the actions of decision-makers (Kingdon, 2011).

Emma: We had met twice but realise that there needs to be a bigger coalition, is bigger than one group, so why don’t we come together as domestic violence coalition which, at that time, one organisation was hosting that coalition that is why a lot more people were mobilised around movement on domestic violence. Because we had done bits and pieces of work scattered, research was scattered but together then we would be able to move forward and make a better impact. So it took ten years to get the law passed.

Emma’s interview extract above indicates that sometimes before women’s groups form the coalition, coalition members may have been doing similar things on their own but the lack of success as individual organisations highlights the realisation that pooling resources help in reaching more important people with the campaign.

Apart from a stronger voice that helps advance the advocacy demands, a coalition inures other benefits to the advocacy process. One such benefit is the provision of a pool of skills. In the advocacy process, there is a need for different skills, drafting of bills (legal expertise), gathering of data (research), public speaking skills, media interaction skills, community and people mobilisation, and many other skills. One of the women's rights advocates discussed this in the quote below:

Well, I think the obvious one is that you have a bigger body to advocate for the same thing and use a big voice to advance whatever you want. The other will be skills that people bring on board, for example, my organisation and another organisation work together on family planning and unsafe abortion, but that organisation will be good in other areas, for example, social marketing, which is something that we can rely on to achieve that aim. They may also rely on us in other technical areas especially expertise in service provision, and in working with government facilities to champion the issues and so at least you can tap on one another's strength to advance whatever you want to achieve. (Ikem)

In a coalition, coalition members put their skills at the disposal of the coalition as their contribution to the advocacy action. Organisations, therefore, tap into multiple resources to champion a common cause. Ikem highlighted the pooling of technical skills together and its importance to the coalition. In the quote below, Harriet explained the different technical resources pulled together through the coalition for the domestic violence law advocacy:

Of course, we realised that one organisation cannot do advocacy so coalition then became one of the considerations and as I said, when we had the data, then FIDA had also come up with a draft of the bill, and those of us who set up the organisation, we are lawyers so we are also part of FIDA, we were also part of Wildaf. There were other organisations like the ARK Foundation which was also set up by lawyers so we were already into each other's business. It was, therefore, easy to bring us together and then based on that once the first draft came up and the AG's office; at a start with that bill, we were able to then invite others who were not part of us to come and join. (Harriet)

From the above extract, it is suggested that one organisation did research to provide data, another also drafted the bill for the consideration of parliament and others played different roles in achieving the results of the domestic violence coalition. In the quote below, Godfred also highlights that coalitions provide the capacity to meet high-level policy-makers.

Where we have especially national issues, we join another coalition, like we joined NETRIGHT, we joined the Domestic Violence Coalition, the women's manifesto coalition, something that is of national, we come together, that gives bigger voice and strength. We have done that by meeting the Minister of Gender several times because we were working on a national issue. We have reached the Minister of Local Government on several occasions about some laws, and we had felt that, when we go in that capacity, the impact would be greater than individual organisations. That should be the way. People should not always look at their self-interest, you will never achieve good results with that.

Godfred in the above quote highlights achievements in reaching policy-makers because of the coalitions formed. He states that when advocates go in the capacity of the coalition, they make a great impact. According to Linda, one of the leaders of a women's rights advocacy group, knowledge is one of the resources made available to the advocacy process in a coalition. Advocacy is usually about policy and law and hence in an advocacy process, it is important to have people who have legal knowledge and expertise to help interpret provisions and draft policies and bills. These lawyers may also not be reproductive health or gender experts and hence would rely on experts in the areas to provide the needed information to draft the policies and bills.

Linda: You know when it comes to advocacy, especially as the advocacy action progresses and it is getting to decision-makers, you need people who have quite some knowledge in legal matters, governance, and that type of thing, so definitely some of the NGOs whose focus areas are in these, tend to take the lead, whilst the service-oriented NGOs, we take the back seat because we have brought information from 'down' (the grassroots) and the others take it up. Although you know, they come back to us to get more information to make their case stronger. Another thing also is getting the facts on the ground.

According to Linda coalitions bring different synergies on board. Some coalition members may not have knowledge in legal matters, but because they work at the grassroots (down) they bring information from 'down', facts on the issues, and members with legal backgrounds use them to draft the needed legal documents. Each coalition member, therefore, brings on board, what it is good at, demonstrating interdependence and blending of different skills and resources. Some participants discussed in detail the need to identify the strength of coalition members (the resources they have) and use their strengths appropriately for the gains of the coalition. As emerged from the data discussed and the data below from Godfred, it does not necessarily follow that if an organisation started the advocacy activity, it has to lead it on all fronts. It is also not just the numbers, but the skills and strengths that the numbers bring on board. The ability to know and utilize the various synergies and strengths is crucial.

There are certain areas that you know that this particular group will lead, and it will be ok. For instance, my organisation is still part of the Ghana Anti-corruption Coalition. We came for a meeting. We are doing certain things together. We are a small group, steering committee, but if we are going to meet the President, there are certain organisations that even when the President sees, he knows that oh, these people are serious. They may not be the lead group, but even their presence is very important. ... So, ... you always let certain people play certain roles within the coalition. (Godfred)

Interestingly, from the excerpt above, the participant asserts that some organisations may not lead the advocacy action but their presence alone, could contribute immensely to the advocacy process. These advocacy groups have a reputation with policy-makers that has been built over years. Their presence alone at advocacy meetings with policy-makers could help policy-makers pay attention to the issues discussed.

Another participant discussed that in the coalition, members could also work on different aspects of an advocacy project so there is division of labour:

We started working together, five NGOs working together, the R3M, towards reduction of maternal mortality and morbidity in Ghana so that was a coalition. We were doing different aspects of it. (Ikem)

Apart from human resources which yield different and enormous expertise for the advocacy process, coalition building also helps to provide financial resources for the advocacy process. Emma states that:

Yes, people bring their expertise, resources; human, financial, even people make their time, that is their contribution because they have that as part of their plans.

According to Harriet, members brought on board funding:

..., so we put those funds at the disposal of the coalition and that is how we did all the national consultations. It was part of our organisational project because for us we knew that as an individual organisation it won't be possible for us to deliver without the numbers.

Harriet further indicated that *"At some point, when our resources run out, Action Aid put in money"*. Harriet's organisation started the domestic violence coalition towards the Domestic Violence ACT. They had funding to implement the advocacy activity. Their funding however ran out because the advocacy took ten years to yield the intended results (Domestic Violence ACT). Coalition members, therefore, started contributing funding to support the advocacy process. A participant also provided that coalitions help organisations to reach geographical areas for which they may not have offices and staff there and this is critical for a country like Ghana with quite remote rural areas.

Emma: One thing is that Ghana is big. Even if you take one district, certain districts are so huge that you alone cannot go and achieve anything, so you need to work together with other organisations...and my organisation is such that we have worked in the North and we have never been to the North. If I say, we have never, I mean building offices there, but we have other associations from the Brong Ahafo and the North that we have engaged. ...You can never be everywhere at the same time.

Members of coalitions can work in districts, regions, and towns where they don't even have offices. From the data, through coalition building, members can share resources and projects with other coalition members, who are in the districts where advocacy projects should be implemented.

In contrast to the above benefits, Emma gave an example of an organisation that started an advocacy activity alone. As the advocacy got to policy-makers (parliament), they could not withstand the resistance and probe by members of parliament on the issues raised and hence could not get positive outcomes on the items they were advocating for.

Emma: But the organisation was doing it on their own, though it is also a legal group, they were on their own. When they had gone to parliament, they were the only group seen, so it wasn't strong enough. There was a lot of resistance to some of the things they were proposing. So, it is very important that when it comes to some of these things, especially about women, you get a coalition.

From the above, Emma indicates that learning from unsuccessful advocacy leads to the focus on joining coalitions for some organisations.

In summary, coalition building is very important in the advocacy process. It makes available great numbers of advocates to the advocacy process, the greater the numbers, the stronger the voice. Coalitions also bring to the advocacy process, different types of expertise, knowledge, and skills, which one organisation would find difficult to gather. Again, human and financial resources become available for the advocacy course. Coalitions make it possible for an organisation to reach geographical areas where it does not have offices. These findings resonate with the Apusigah Tsikata and Mukhopadyay (2011) assertion that networks are significant in the policy-making process. Viterna and Fallo's (2008) argument that coalition provides NGOs with people power in information, resources, and expertise is confirmed by participants of this study. The unique nature of the geographical area of Ghana brings an addition to the benefits of coalitions; the ability to work in other geographical areas where the women's rights advocacy group does not have a physical presence. Irrespective of the above advantages, there are dynamics in coalitions that, if not properly handled, could pose challenges to the advocacy process. The next section discusses these dynamics and their challenges.

7.1.4 Dynamics and Challenges in the Coalition

There are dynamics in coalitions that could contribute to making coalitions successful or not successful. In discussing the challenges and dynamics in coalitions, participants mentioned commitment, the experience of partners, and tolerance as key to making coalitions achieve the aim for which they were formed. According to Grace, coalition members bring a lot of passion to the work because most often coalition members are direct beneficiaries of the intended outcome of the advocacy project. They may have been directly or indirectly affected by the lack of policy or enforcement of the existing policy on advocacy issues. This resonates with the concept of representation discussed in chapter four that the target beneficiaries of the advocacy issues participate in the advocacy process so that advocates work "with" not "for" the target beneficiaries. So, in these advocacy groups, apart from members being women and hence having a passion for women's issues, some would be directly affected by the issues being advocated for. Grace's quote below attests to this claim:

Maybe it is the passion; you know the passion of people who get involved - they want things to be done and to be done immediately. Because they are the people suffering, they quickly want to talk and make the changes even within the twinkle of an eye. Some are small, so you see other strong ones leading because they have the resources and you see the weaker ones running behind them. (Grace)

Grace's explanation of passion above is the desire to see things done and not a display of lack of thinking. Women's rights advocates agree Grace's submission is indicative that coalition members who have resources are stronger in the coalition and hence may naturally be found leading the coalition. Smaller groups, therefore, are found running behind the big, well-resourced groups providing support. Grace's position on the issue of leadership, however, may be a little different from another participant's, Godfred. In the interview for this study, Godfred claimed in the excerpt below that resources alone do not make a coalition member qualify to provide effective leadership:

And so, then, you don't necessarily have to lead even if you have the resources, you have all the money, and the biggest office, you don't have to lead. You should rather let the group with the clout lead and push them. So, these are some of the dynamics, but you know as far as we have two people in one place, there will be conflict always.

According to the participant, a member may have the resources but not the skills and status (clout) to be an effective leader. There may be coalition members who are well known and respected in that area of discourse and may provide the needed leadership. These are some of the dynamics in the coalition during the advocacy processes. If they are not handled well, they may lead to the disintegration of the coalition as members would want to protect their interests. Those who brought funding may want to be leading, and those who have connections with policy-makers may also want to lead.

These "controls" and complexities in coalitions are recognised by Emma who provides insight into the leadership of the Domestic Violence Coalition:

Hmmm, not more important but I know that the ARK Foundation was made to lead because they had devoted about 5 years of work, just working on the domestic violence issue and they had funding for it as well.

From the above, Emma proffers that the choice of the ARK Foundation to lead the Domestic Violence Coalition was based on their many years of experience in working on domestic violence. It is important therefore for coalitions to have a clear leadership structure. Harriet had earlier, also claimed that her organisation had funding and brought it on board for the advocacy but agreed that the ARK Foundation should lead. Action Aid also brought funding when the ARK foundation was still leading. So, Godfred's position that resources alone are not a determinant of who should provide leadership in the coalition's work

is evident in the data provided by participants of the Domestic Violence Coalition. Experience also played a key role in who should lead.

According to Harriet, to forestall the challenges of who leads and to minimise conflict, the DV Coalition set up a steering committee to formalise the process by which coalitions work together. The steering committee has members from different organisations so it would not appear that one organisation was leading:

Coalitions can be effective at the same time they can also bring out hostility between those who are involved. What we did with the DV coalition was then set up the steering committee. I can say that Gender Centre started all of these things but when they brought together other organisations, we said ok, another organisation should be the secretariat so we had WISE acting as the secretariat of the coalition. (Harriet)

It is evident from the above excerpt that even apart from the steering committee established to lead the coalition in the advocacy work, a different organisation was also picked to host the secretariat of the coalition. The above arrangement aimed to distribute power and hence hostility and challenges around leadership is reduced. Harriet further gives insight into how the Domestic Violence coalition handled the challenges of leadership for the coalition to fulfil its mandate:

Harriet: No, Abantu was part of NETRIGHT but was not part of the DV Coalition. Abantu does not work directly in violence. So we formed the steering committee and so it wasn't as if it was one organisation that was leading. So I think for me, the importance of coalitions if you want to make it work, is to recognize the importance of each group and every individual in it. Recognise that every group, every person is important. If you could have done it alone, you would not have brought others on board, so if you have, then you must let them know that they are also important so their voice should also be heard in the coalition.

According to Harriet the distribution of power also means that the importance of each member of the coalition is recognised. It is critical for each coalition member to feel involved and to contribute to the coalition's work. Harriet asserted that one of the areas that can bring challenges in a coalition is who takes credit for work done. There are some organisations or people who will not be engaging but they would demand acknowledgment for work done by the coalition.

Harriet: But what I can say is that probably at the end of the story some organisations were not acknowledged. And sometimes, we want to blame others, I saw two publications that had told a story that was not how it was. They had given credit to an organisation that was not a member of the coalition. For some of us, that was not too crucial. So, any time I talked about Domestic Violence Advocacy, people say please give us the correct stories. But Coalition could be challenging, some people will be going on the ride without necessarily engaging, but whatever it is, we still need the numbers.

The above challenges in a coalition are expected since the coalition is made of up many groups and organisations, some of who have never worked together before and some who may have worked together

in the past as discussed also in the literature reviewed (Honeycutt and Strong 2012). The organisations have different organisational cultures and may have different agendas even in the coalition. Godfred also indicates that in coalitions some members also attempt to suppress others because they think they are experts in the field of the coalition's work and that they are ahead of other coalition members. This also brings challenges as some organisations are unhappy:

Godfred: Then it also happens that since I am the professional or have expertise in this, I want to lead. Some people try as much as possible to suppress the rest so that they would be projected. If you continue to do that people will withdraw. You will call them, and they will not come. But when you see all of them playing key roles, their presence alone, without talking is enough...

Such suppressive behaviours drive some members out of the coalition, and it affects the work of the coalition since they leave with their expertise, resources, and voice, however meagre.

Competition for resources is another challenge that occurs in coalitions as discussed by the sampled participants. Sometimes, coalitions write proposals together and seek funding together. But usually, the funding will be disbursed to one organisation whose details will be presented to receive the money. Such organisations in some instances had felt reluctant to make the funding available to the coalition for its work. They tend to control the funding and it is also perceived that they use the funding for their own organisations' benefit. Sometimes, the funding will even be released to one organisation before the others would know.

Ikem shared an experience:

I remember when an embassy approached us to form a coalition to use their funds to do Maternal Health Channel, we formed a coalition. Before we realised the money had gone to only one of the members. That is how NGOs work, that is how coalitions break.

According to one participant, this is one of the reasons why coalitions break. Ikem provides further insight that competition over resources occurs because most women's rights advocacy groups compete for resources from the same sources:

Ikem: Problems with the NGOs will exist because they compete for the same resources. ... Where there is money you find a lot of NGOs aggregating there. Let me give a small example, I formed one of the coalitions in health, when there was money for malaria, all the NGOs tune to malaria, and when there was money for TB, everybody joins TB. Where there was HIV, a very sexy topic, all the NGOs became sexy in HIV. Now the sexiest topic is Sexual Reproductive Health, a lot of NGOs are coming up with doing sexual and reproductive health.

From the above, the participant claims that apart from competing for the same resources, women's rights advocacy groups move into projects where funding is available and also they work on issues that are trending (sexiest). From Ikem's quote above, topics trend depending on availability of funding. The competition for funding and its effects are well documented by Boadu (2019). Idris also shared his experience with competition for funds in the two health-related coalitions:

Later on, one of them who had control over funding moved to a full campaign. One organisation was to host the campaign but because they were not registered on the donor's system and for that matter, the donor could not transfer money to them, it was decided another organisation should host for one year. It hosted for one year and did not want to give it back to the original host organisation. This became a tug of war. The organisation tried to hold the advocacy project to itself. They never wanted to let go and that created acrimony. So sometimes selfish reasons, personalising the coalition, ownership issues, and control of resources are the issues. (Idris)

Some organisations take advantage of leadership arrangements because of their position to receive funding and attempt to control the coalition's work. According to Idris, coalition members perceive that leaders take advantage of the leadership role to channel funds to their organisations and such selfish behaviours break coalitions. Idris further proposes solutions to these dynamics and their effect in his excerpt below:

You need to have your guidelines, sometimes people will want to use the resources or platform for their agenda. There is nothing wrong, but it should not be done to the detriment of the coalition. I knew one organisation that was chairing a Coalition and then, later on, I realised the organisation tried to use the resources of the coalition to run its affairs, and later on criminal issues were levelled against the organisation. I was very angry. Virtually they kicked that NGO out. That behaviour was very wrong.

Idris' response indicates that when an organisation in a coalition has anti-social behaviour it can be sacked. This demonstrates effective management of coalitions, their resources, and excessive negative dominant behaviour. Another participant also discussed a challenge in a coalition when coalition members may have allegiance to a particular political party and hence retreats in case they perceive the advocacy as too hostile to their party. This can happen when the advocacy gains momentum and policy-makers resist the advocacy demands. When the relationship between policy-makers and the coalition goes sour, coalition members affiliated with the party, tend to retreat. Idris recounts an experience during a health campaign:

And when the research finding came out, the government decided to fight the findings because it felt it was damning. What happened was that a member of one of the coalitions tried to backtrack and tried not to associate itself with the findings because of its interest. I found it very unfortunate because this was something that was done very well and the methodology was good. (Idris)

Idris provided the background to the above situation:

...Now what their team tried to do was to discredit the report and said the methodology was not right and then tried to get parliament to fight it. They were antagonistic but we did not give up, eventually one day they conceded and they started changing and revising some of the issues, and finally, we were there.

Hostility from policy-makers became a barrier for groups who had affiliations to the government to continue to engage with the policy-makers. This is because they could be perceived as opposing the party to which they may have shown openly that they are affiliated.

Irrespective of the above numerous coalitions discussed as formed in Ghana and even with a good number still operating, Ikem says that Ghana has not positioned itself in coalition building as far as women's health is concerned:

Unfortunately, Ghana has not positioned itself very well in coalition to advance women's health. You find a lot of NGOs doing things on their own with a lot of NGOs doing Sexual Reproductive Health now, in their small way. I strongly suspect that because we are externally funded people think that when they join you, you are in a better position to swallow them up.

The above extract from Ikem is an important view about limitations of effectiveness and the need to build more focal coalitions around women's health. Despite the challenges in coalitions discussed above: leadership crises, competition over resources and hostility, and political affiliations, it is clear from the discussions that women's rights advocacy groups regard coalitions as indispensable in successful advocacy campaigns especially advocacy on national issues and women's issues. When these challenges are addressed, coalitions would work to the advantage of the advocacy processes and the benefit of all group members. Idris sums up below:

You need support. You need solidarity. You need the numbers so it is very important. But then you also need to manage it very well because the dynamics will always be there. What you need to do is to define the role of everybody. Everybody should be given a role to play. It shouldn't be like some are just followers and some are running the show. No, because it is different resources that are coming together and each of them is doing something unique, that is why they all identify themselves with and they are passionate about it... But you need to always work together, shape the issues, and the agenda, and there must be a central coordinating body. (Idris)

From the quote above, Idris summarises what needs to be done for coalitions to achieve their aims: the role of each member needs to be well defined. It improves commitment to the advocacy cause; The contribution of each member should be recognised and there should be a central coordinating body. For the Domestic Violence Coalition discussed above, the setting up of the Steering Committee provided that coordinating role.

This section has presented the discussions on the formation of coalitions and evidenced the formation of coalitions and joining of coalitions are important strategies for advocacy groups in Ghana. Many advocacy groups join coalitions. Though a few advocacy groups may not be permanent members of coalitions, they still collaborate with coalitions to execute their projects. The analysis of the data available indicates that the level of contributions and the level of involvement of coalition members will differ, Viterna and Fallon (2008). The dynamics of coalition building can lead to conflict around leadership, competition for resources, and controlling behaviours. However, coalitions still have many advantages to the advocacy process in

Ghana. The advantage of having all people on board is still achieved: numbers and a strong voice. Again, a pool of many organisations also implies a pool of many leaders: people who have played leadership roles in their various organisations (Honeycutt and Strong, 2012). This inures benefits in the areas of resources and skills. Participants in this study suggested that setting up the steering committee is an important strategy to manage coalitions during the advocacy process. The section also mentioned some important coalitions in Ghana, how they were formed, their nature and the advocacy actions they pursued.

Pooling resources together for coalition's work has been discussed above as one of the advantages of coalition building. Competition over resources has also been discussed as one of the key dynamics that could mar the work of coalitions. The section below discusses funding priorities of women's rights advocacy groups, sourcing for funding and difficulties in obtaining funding for women's reproductive health issues and violence against women.

7.2 Advocacy Funding Priorities

Funding of Advocacy action is one of the frequently discussed subjects, especially among key stakeholders and organisations who are into women's rights advocacy (Apusigah, Tsikata and Mukhopadyay, 2011). However, to examine advocacy funding priorities holistically, this section was divided into four parts: advocacy funding priorities and the donor community, difficulty in accessing funding for women's rights advocacy concerning violence against women and women's sexual reproductive health and rights, strategies adopted by women's rights groups to ensure sustained funding for advocacy projects and the need for collaboration in fundraising.

7.2.1 Funding Priorities and the Donor Community

It was gathered from the participants of this study that the financial resources required to carry out advocacy in Ghana are one major prioritised item that advocacy organisations look out for before considering any other resources. Funding priorities for advocacy focus on specific areas of interest that are in line with their missions and vision organisation. Based on the general belief that financial resource is the main concern when undertaking advocacy in Ghana, Grace, one of the participants, recounted that:

We look at resources because if you come out with a policy, you need resources to implement it, and you must put systems in place to monitor the implementation of the policy to know whether it is working or not working. It is not like just developing policies, you take the money, and then you put it on the shelf. So, we look at all these things.

As per Grace's submission, women's rights advocacy groups need resources to monitor the implementation of policies. So, advocacy does not end with policy formulation. It continues to monitor the implementation of the policy and this requires funding. This confirms Pressman and Wildavsky's (1988) position that the implementation of policy is as important as its formulation.

The data gathered from the study's participants depicted that most advocacy organisations plan to fundraise for targeted projects and programmes. In terms of priorities, participants agreed that their organisations had predetermined projects based on the plan of work, while some of the programmes or projects emerged on the field when the scheduled ones were being executed. Yvonne, in the quote below, describes how financial priorities are set:

It depends on the thematic area we are working in any reporting financial year, we start in January to December. Every year, Management will sit down and discuss how to raise funds for activities. So there are two ways, we decide on themes and also look out for calls that are advertised, there are so many thematic areas when it comes to human rights but it is not everything we can do, so what we do is to look out for those areas that first of all, we have interest, we have the capacity and the money is good enough to roll out the project. Sometimes too in the field where we work, we find out about a particular issue, develop the concept and share it with donors without necessarily waiting for a call. (Yvonne)

According to Yvonne, fundraising is directly linked to the thematic areas of focus for the organisation. This exercise informs which calls for proposals the organisation will respond to. Calls for proposals are usually advertised by the international partner/donor. The key consideration for responding to advertised calls for proposals are interest and the capacity of the organisation to execute the projects. Yvonne also reveals that her organisation develops projects based on feedback from the field (their activities) and source for funds even if there is no advertised call for proposal. Grace, however, indicated that sometimes women's rights organisations could write proposals to funding organisations but will not get them approved for funding. The extract below from her expands on the issue:

Grace: We prepared a project for one of those donors; the UN, requesting for funding and its advocacy. They responded that they have several projects and so they could not afford them. And so mostly that is what happens, but you have looked at your country and know what you need to do but they also have their agenda and they want you to follow their interest. It is difficult and so if your proposal does not align with their interest, it is difficult to get the money and that is one of the biggest challenges.

The dynamics of funding priorities of donors are critical in the ability of women's rights groups to obtain funding. The funding request, though as Yvonne indicates, can be planned by women's rights groups, donors' interest drives funding for advocacy. This, according to Grace, may not necessarily align with the need of the country as analysed by the women's rights groups. Another participant, Emma, who discussed

the Sisters' Keepers coalition also indicated in the quote below, the same stand on donor interest driving fundraising.

Usually, we find that some of these things, we would follow up where the money is going because for us in 2008, it was a call for research from those working on HIV/AIDS. The UN women also came up with a call for research on property rights of women living with HIV and AIDS, both pieces of research came up with interesting findings about what was happening with women living with HIV. So, we find that that is what the donors want us to do. (Emma)

Emma ends her discussion on funding by saying that they seek funding based on donors' interests. Interestingly, Harriet also confirms the same when she stated:

And even now sometimes, funding is not specifically for violence against women or for women. There is a lot of shifting to adolescents, so for us, we are doing adolescent work; we always ensure that it is part of the work we do. (Harriet)

Harriet thus confirms a shift of focus from advocacy on violence to advocacy on adolescent reproductive health because that is where the interest of donors is.

Ikem also recounts similar issues in the quote below:

Let me give a small example, I formed a coalition of NGOs, when there was money for malaria, all the NGOs tune to malaria, when there was money for TB, everybody joins TB. Where there was HIV, a very sexy topic, all the NGOs became sexy in HIV. Now the sexiest topic is Sexual reproductive health, a lot of NGOs are coming up as working on sexual reproductive health and rights. We have maintained our focus. Ours is sexual reproductive health and rights, So, it is quite a daunting thing.

It is interesting to note however that Ikem's organisation has maintained its focus on sexual reproductive health and rights. He states that this is a "daunting task". It presents a real challenge for continued funding for the organisation. Thus, for the sampled women's advocacy groups in Ghana to secure funding for their programmes, they should be able to do a lot of consultation and research on donor agencies' priority areas they are prepared to invest in. Organisational planning and mission get distorted by donor interest.

7.2.2 Difficulties in accessing funding for advocacy programmes in Ghana

Ikem and Harriet's submission discussed above gives a hint of difficulties in raising funds for advocacy actions. Some of the study's participants were of the view that comparing the recent situation, in terms of advocacy funding, to what was the case in the early years, inaccessibility to advocacy funding is now worse. In chronicling variations in advocacy funding regimes and their impact on advocacy actions in Ghana, Harriet had this to say in response to a question on advocacy funding:

Funding? I can say that in the late 80s, the late 90s, and early 2000s, violence against women was the thing so it was easier, usually, with a good proposal it was easy to get funding, we got funding

from DANIDA, from the British Council, and the UN. So at the time, when we developed our project we got funding from a UK organisation, Comic Relief, we got when we were doing our HIV work, we got funding from DFID but for the last eight, or nine years, it has been difficult.

Harriet clearly states that for almost a decade now, funding for advocacy has been difficult. The data above lists important organisations which used to fund her group's advocacy activities. Her submission could imply that these organisations are now not funding their advocacy activities on violence against women as they used to do. Harriet provides insight into what might be the cause in the extract below and Grace, one of the participants articulated the common frustration women's rights advocacy groups go through and the possible cause.

I think probably, not because violence has ceased to be an issue, but because I think as a country, we are no longer on the way of most of these funding agencies, and especially in the last six years, since Ghana is supposed to have attained middle-income status, it has been a real challenge. ...But it is not easy, since the year 2000 up to about 2009-2012, we had many very strong women's rights groups that we were working with on violence but currently, organisations like the ARK foundation which had looked at shelter, the only shelter organisation has closed down the shelter. WISE has closed. It is a real challenge. (Harriet)

Before you can get money for advocacy it should be part of what the donors want to fund, and those donors, because advocacy is long-term, you need time before you can see the results. It is not like an activity to go and implement and immediately get the results. We need resources to do proper advocacy. And some of them you can do the advocacy but you will not get the results. And so you have to go back, so it is difficult for donors to put in money because most of them need quick results they want to see what their monies are achieving, at the end of the year, give us the report, and so it is difficult. (Grace)

The evidence gathered from the advocacy groups interviewed indicated that the funding challenge facing advocacy organisations in Ghana is widespread, and not limited to only one entity. Harriet indicates some organisations closing down or closing part of their programmes. According to Grace, one of the challenges with getting funding for advocacy actions is that advocacy is a long-term activity. Results are not achieved in the short term and sometimes the desired results may not be achieved at all. The participant also discussed how the economic policies and indicators of the country affect funding for women's rights advocacy groups. The Government policy and pronouncements that Ghana had attained a middle-level income status, led to a dwindling of donor funding because the country was perceived to be financially viable and hence did not need much aid. It could then be expected that government funding for health and related advocacy would increase. But the data provided by the participants of this study indicates otherwise. Godfred recounts the funding mechanism in Ghana for NGOs:

One thing about Ghana is that the Ghana government doesn't have a funding mechanism to support NGOs or CSOs so we get our funding from outside the country, always through proposal writing,

donors such as EU, DFID, DANIDA, Cross Roads International in Canada, Womankind Worldwide in the UK, and others that have come and gone. ALAPHPAAMI, they have pulled out of Ghana. In those days they were supporting us, SNV doesn't give the kind of support they were giving those days. So this is how we are funded. There is a local organisation also known as STAR Ghana which is a kind of pool fund manager providing support to Civil Society groups in Ghana.

All funding/donor partners listed are foreign or international agencies and groups except STAR Ghana which is described as a pool fund. Godfred's data confirms the position of all participants on overdependence on donor funding for the implementation of advocacy activities which reflects Ghana's health financing and related issues in general. This is also indicated in literature by Asante and Zwi (2009).

Irrespective of the above stand on overdependence on donor funding, some advocates indicated that they got support from the Ghana AIDS Commission. One of the advocates accounts is below:

In 2016 Ghana AIDS Commission supported us with some funds and the fund aimed to train women so they can have something to do on their own. So that they will not rely on others. So, we were able to train the beneficiaries in beads making. (Felicia)

Another participant stated:

We get money through the group's self-support (dues), Philanthropists give, we write proposals also to source for funds. UNFPA, Marie Stopes International, and the Ghana AIDS Commission support our work. (Akosua)

However, the Ghana AIDS Commission also depends largely on funding from international partners. A policy-maker recounted that:

We were responsible for the hands-on-work; dealing with the partners, ensuring that funding would come in, supervised and coordinated the work of all partners. (Mabel)

So from the policy-maker's point of view, efforts were done to ensure funding of women's groups. In the excerpt below, Mabel recounted challenges around funding, but her agency ensured that they fund women's groups when they could:

So we had to build the capacity of women's groups to a certain extent, ensure that when funding was available, even when funding was not available, priority was given, with approval, of course, by the Board, for specific calls for proposal on the key issues that had been advocated for by these groups for their work. Sometimes, funding was reserved for their work, especially on the issues of female condoms. And programmes were carried out consistently, so because of the inconsistency with funding for CSOs, there were times that there was a lapse in funding for these CSOs but there was always, usually a reserve that was made for, especially the last 2 years, for female condom programming by women's groups.

Mabel confirms the inconsistency of funding for CSOs but efforts were made to fund women's rights advocacy groups. The inconsistency of funding negatively affects the work of women's rights groups and

their advocacy work. In contrast to the efforts made by Mabel's establishment, Odo, another policy-maker reacted to a question on whether her establishment funds the work of women's rights advocacy groups:

No, we are Ministry seeking for funding. How can we give NGOs funding to carry out their objectives? It is not done. We are government and we also are at the mercy of development partners.

So, it is evident that the Ghana government does not have a funding mechanism for women's rights advocacy groups although some agencies do source funding and support women's groups. Meanwhile, much of that funding also comes from the same source where these women's rights also write proposals to seek funding: international partners.

In expressing her frustration regarding the difficulty in accessing funding, Ama, one of the women's rights advocates averred:

You see, when you have funds, it makes you more active, it is extremely difficult working without funding, except that you are committed so you should move out to go and help the vulnerable.

7.2.3 Ensuring Funding for Advocacy Activities

Women's rights advocacy groups however found ways to ensure funding for their advocacy work as much as they could. Grace and Ama told me that their organisations try to mainstream advocacy on violence against women and reproductive health into all their proposals but even that is still difficult. Their quotes below evidence this position:

As an organisation, we tried to mainstream advocacy into most of the activities that we do then we write advocacy proposals, but it is not easy getting those resources, so we look at our platform because we have the staff who have the capacity. We talk to our allies, so we just use those existing resources to do our advocacy. It is not easy but more on our domestic organisational resources, we put small resources together from our existing programmes like people's time to support our advocacy. (Grace)

Last year I got small funding for malaria from the Ministry of Health to do a programme on malaria prevention and management. So anytime I have a project, I integrate reproductive health advocacy programmes, especially this teenage pregnancy, because of our socio-cultural milieu, once the child becomes pregnant and has the baby that stalls the future of the girl. (Ama)

Some of the funding strategies have been to integrate reproductive health activities into their existing projects like malaria linking them to reproductive health, leverage staff capacity and use staff time unpaid, and also get support from allies who are also women's rights groups in advocacy.

Godfred reveals that corporate Ghana has also not helped provide funding support for women's rights advocacy:

The difficult aspect is that corporate social responsibility has not been effective in Ghana, especially towards NGOs. This connotes a dire situation where even sometimes; women's rights advocacy groups have to use their resources to engage in advocacy.

Ama indicates that “*In fact, fundraising has been a major problem and I use my resources a lot*”. She uses her resources for advocacy for reproductive health. This confirms that women rights advocacy groups are policy entrepreneurs, ready to invest resources for policy gains (Kingdon, 1984; Mintrom, 2019).

Another dimension of the countless challenges advocacy groups in Ghana are confronted with is the delay on the part of the donor in releasing funding in support of advocacy programmes even after the funding approval. For instance, in their study, Apusigah, Tsikata and Mukhopadyay. (2011) recounted that the work of one renowned Women’s Rights Organisations, which targeted some selected women in local government in Ghana, started very late because the single donor had unjustifiably delayed in its decision to endorse and disburse proposed funding which affected the programme. The available evidence uncovered in this study, which is similar to studies portray that the activities of women's rights advocacy groups in Ghana are impeded due to a lack of funding, and this has resulted in their reliance on foreign donors. But Walsh (2016) has observed that donor agencies always try to control and strictly manage funding to the point of instructing and directing local advocacy programmes, hence the seemingly delay in the release of funding meant for advocacy programmes.

7.2.4 The need for collaboration among advocacy groups to access funding

The lack of available funding sources has engendered some Women's Rights Organisations to form new coalitions, which is generally positive for increasing their resource portfolios (Apusigah, Tsikata and Mukhopadyay, 2011). The current data for this study indicated that almost all the women's rights advocates who were interviewed acknowledged the need for more advocacy organisations in Ghana to come together as a coalition and work toward a common goal. However, the leadership’s willingness to make this happen is non-existent because of competition. This challenge was well articulated by one of the participants, Godfred:

This is because we compete for resources, so the host of the coalition feels like I should get certain resources to do the work, and when they see you also doing similar work, then that kind of mad decision comes in. It happens. Now there are other coalitions also that, we knew that, if we depend on this particular organisation, we will go far. Sometimes it is also through collaborations with other international NGOs or other NGOs outside Ghana, so we collaborate with them. Womankind, for instance, has always been a collaboration. Thus with Crossroads, it has always been a collaboration because they also get funding from elsewhere and they bring the project for us to work together.

As indicated in the data results presented above, it is obvious that although some level of competition exists among individual advocacy organisations, such does not take away the importance of coalition formation. This is not different from Boadu's (2019) observation that in most cases advocacy funding provided by foreign donors is easily accessed when different advocacy organisations form networks, collaborate, and champion one course. Specifically, doing away with internal competition and focusing on building partnerships and coalitions as women's rights advocacy groups would provide a common platform for dealing with issues that affect women in general. This is in line with WHO's (2013) position that nurturing advocacy coalitions and integrating programmes will strengthen national advocacy for improved women's and children's rights and health. On top of this, Apusigah Tsikata and Mukhopadyay (2011) have also recognised in their study that coordination through harmonisation of programmes has helped in pooling financial resources at both the donor and national levels and this has worked for advocacy NGOs to adopt collective tactics using networks, coalitions, and partnerships. Based on the findings supported by prior empirical studies, the value added to the body of knowledge is that the cost of working in isolation as women's rights advocacy groups cannot be commensurate with the outcome of other advocacy actions when networks coalitions and partnerships are formed for a common goal. More so, access to funding, which is the major challenge for most women's rights advocacy groups in Ghana, would not be a problem when advocacy funding is sought by a group of women's right organisation instead of individual entities.

7.3 Conclusion

The data from this study revealed that international donors provide substantial funding for women's rights advocacy groups organisation in Ghana. Overall, it can be inferred from the data analysed that lack of funding has affected several women's advocacy groups in Ghana to the extent that some had to fold up or re-strategise; others had to collapse completely. These real challenges as recounted by the participants above confirm the position of different prior studies (Medie, 2016; The Equality Institute, 2019; WHO, 2020; Walsh, 2016) which have established that funding for galvanising advocacy actions to protect women in Africa remains the greatest obstacle to the actors who are committed to pushing such an agenda. However, there are still some donors who believe in the capabilities of the women's rights advocacy groups and continue to fund them. It is also evident that women's rights advocacy groups demonstrate commitment to their cause by adopting innovative strategies to ensure continuous funding for advocacy activities and even sometimes, they use their resources for their advocacy.

CHAPTER 8: CONCLUSION

8.0 Introduction

Women's groups have engaged in advocacy actions to influence policy change or enforcement of implementation of existing policies to improve the reproductive health of women and eradicate violence against women, which is one of the key determinants of women's reproductive health. The rationale of this study was to find out the perspectives of women's rights advocacy groups on their role in reproductive health policy formulation and implementation in Ghana and how they construct these roles. The structural extent of gender inequality means most nation-states do not typically adopt feminist changes without pressure from organised groups of women (Viterna and Fallon, 2008). This study evidenced that women's rights advocacy groups in Ghana being aware of this, have organised around gender-based violence and reproductive health to bring pressure on the government to enact policies, and laws and ensure the implementation of existing ones to improve the quality of women's reproductive health and rights. Adomako Ampofo (2008) confirms that women's movements have effectively mobilised and organised around gender issues and political actions/actors in recent times.

My observations and experiences (as an advocacy practitioner) and from the literature review about women's rights advocacy groups in Ghana found that the area of their activities around policies and politics and how they engage the policy processes were not well researched. Again advocacy activities on gender-based violence and women's reproductive health were usually not carried out together. This thesis therefore explored:

- How and why do women's rights advocacy groups and other policy actors conceptualise and frame the relationship between women's rights, gender inequality, violence against women and reproductive health rights in the Ghanaian context?
- Analysing the perspectives and experiences of women's rights advocacy groups and other policy actors, how do they pursue and practice advocacy in this area? And what influences effectiveness and impact?

To achieve this, the sub-questions below guided the research:

- How do women's groups conceptualise and evidence the relationship between violence against women and women's reproductive health during the advocacy processes?

- How do advocacy groups construct and frame the problems of inadequate reproductive health rights and services and violence against women; and the proposed/preferable policy changes and alternatives?
- From the perspectives and experiences of women's rights advocacy groups and policy-makers, how do resources, relationships and context influence the advocacy process and impact?
- What are the tactics/strategies used to achieve advocacy outcomes?

This concluding chapter is in four sections. In the first section, the overarching findings of the thesis are summarised. The second section is a reflection on the methodology; methods, sample population and techniques, and data used in this study, highlighting key strengths and limitations. In the third section, the wider social/policy significance of the study and its findings are offered. This comprises the suggestions from the interviewees and also the researcher's interpretation of and analysis generated from the primary research data. The research aims at emphasising the role of women's rights advocacy groups from their own perspectives and hence the need for further empirical research on the participation of women's rights advocacy groups in the policy-making process in Ghana. The fourth section emphasises the wider policy implications of this study.

8.1 Key findings

8.1.1 Characteristics, motivations and social positions of women's rights advocates in Ghana; and how these influence their actions, resources and practices.

The major cross-cutting themes that emerged during the data analysis included similarities and differences across participants in how they constructed and focused the primary goals of their advocacy organisations around the issues of reproductive health and violence against women. The backgrounds of the women's rights advocates indicated that most of them are highly educated. There are lawyers, journalists, professors, founders of their groups/organisations, social workers and reproductive health and gender experts. Except for two advocates who did not have higher education, the rest are well educated. Even those with no higher education, have become empowered because through their advocacy, they have been exposed. These women therefore consider themselves privileged to have positions and opportunities which many other women do not have. They therefore use their privileges to mobilise other women and lead advocacy activities to improve the reproductive health and human rights of women.

The women's rights advocates interviewed for this research perceive that they are the voices of their target beneficiaries and represent them in the policy-making process to ensure that issues that affect the lives of

the communities receive policy attention. They construct advocacy as talking on behalf of people. To the participants, advocacy is to give the voiceless a voice. Participants emphasised that advocacy means speaking for those at the lower level to make sure that policy-makers act on issues of the rights of the communities and the vulnerable. This position of participants is informed by the view that the people affected by reproductive health issues or gender-based violence may not have access to policy-makers to make their demands or they may not have the power to be heard by policy-makers and duty bearers. Advocacy, therefore, ensures that someone who has the voice or whose voice can be heard represents the target beneficiaries and the advocates take on this role. Alleviation of the suffering of the voiceless, making them less vulnerable and ensuring their access to services as a right is mentioned as the overarching motivation for advocacy. The above standpoint places the affected people as vulnerable and without a voice. According to the advocates themselves, advocacy leads to improvements in the quality of life and health of their target beneficiaries. But an alternative opinion expressed is that advocates do not have to talk on behalf of the people, but that they *'talk with the people and not for the people'*. With that understanding, the issue of vulnerability is limited, and certain voices are given to the people affected. The concept of representation, therefore, becomes participatory as beneficiary communities become participants of the advocacy and not mere receivers of benefits. This makes people and communities empowered to be supported to act on issues that affect their lives. These different perspectives resonate with the debates about how to pursue advocacy in partnership with the affected (Kirby *et al.*, 2008). Even in the perspectives where advocates talk on behalf of the vulnerable, the affected communities are mobilised through meetings and demonstrations and hence they still participate in the advocacy process. The difference may be the degree of participation and terminologies. These debates shape the constructions of practice and goals of advocacy in Ghana. For this purpose, advocates create various platforms: stakeholder meetings, media engagements, interface meetings, consultative meetings, and grassroots data gathering to ensure that the vulnerable, women and girls, and their communities are heard in the advocacy process. A bottom-up approach to policy-making is thus recognised by the women's rights advocacy groups as they apply their advocacy along those lines to be able to achieve their goals.

8.1.2 The wide-ranging understanding and development of the role women's rights advocates play in all phases and aspects of the 'policy process' and 'social change process'.

The women's rights advocacy groups interviewed for this thesis demonstrated the importance of their role beyond framing and agenda-setting to include policy-making, legislation drafting, and promoting effective implementation. This challenges theories that limit the role of advocacy to just agenda-setting. It also demonstrates that advocacy and policy-making are not distinct arenas. They are more fused and fluid and

that advocacy is essentially part of the policy-making process, providing the ‘other angle’ of those affected by the policies. In this regard, the affected and their representatives seize opportunities to participate in the policy-making and implementation processes of the country.

Achieving policy/legislative and social change on Sexual Reproductive Health and Rights

The key finding in chapter four was that the women’s rights advocacy groups constructed their roles as achieving policy change and social change. In this construction, they embarked on policy formulation, pushed for legislative instruments, held the government accountable, and monitored the implementation of policies and the mobilisation of state resources. All their actions were orientated toward the benefit of disadvantaged and less powerful groups in society and the protection of the rights of people. Women’s rights advocacy groups work toward cultural change and the promotion of the very idea of rights and justice by women's rights advocacy groups. To achieve this, they raise awareness on policy issues that concern the communities they represent. However, it was evidenced that advocacy for awareness-raising which culminates in cultural change on how women perceive their rights and agency is usually at the community level: engaging community members on issues of vulnerabilities and protection of their rights. Raising the awareness of rural women is considered an empowerment process for informed reproductive health choices and eradication of the factors of vulnerability, such as lack of information and knowledge on their rights. Some people may experience violence and have limited access to reproductive health because they do not have information on their rights. This corresponds to women’s level of education and access to information coupled with religion and culture which put women into suffering (The Borgen Project, 2018; Cusak, 2009; Offei Aboagye, 2004). The availability of information and knowledge can bring a cultural change and perception of rights, and this can produce cultural orientation and empower women to demand their rights and access to reproductive health. Though advocacy is in various spheres of society, awareness creation at the community level helps bring up issues from the grassroots to the attention of the policy-makers and thereby connecting communities to the political process. By the emphasis on being actors at the grassroots, women’s rights advocacy groups legitimise the representational role of their target beneficiaries.

The data indicates that in working on policy and social change, advocates propose new policies and laws, and propose amendments or reforms to existing policies/laws. This research found that women’s rights advocacy groups, in the advocacy process, play roles, which in other countries are reserved for the legislature/government technocrats such as drafting Bills and developing training manuals for institutions. The drafting of the Bills also connotes that women's rights groups have diverse and extensive knowledge and skills, and they could perform roles, which traditionally, may not be advocates’ roles. “Diverse skills

and peculiar experiences are needed by women's rights advocates in the policy-making process. Working closely with legislative-making bodies is therefore viewed as a legitimate and necessary advocacy action. As part of influencing and shaping policy agendas (the goals), advocacy groups make links with and communicate with policy agencies and hold various consultative meetings with other policy actors for effective advocacy.

Achieving legal change in formal rights is on the basis that policy frameworks alone did not secure rights. Advocacy groups advocate for the enactment of laws because though policies are good and they provide guidelines for the protection of rights and provision of services, they are not legally binding and, in that situation, women are not able to seek redress when they are abused or when they are not able to access reproductive health services. To make policies legally binding, a Bill must be passed into law. When it becomes legally binding there are punishment and enforcement processes that support women to invoke their rights by seeking social justice. Through this activity, women's rights advocates demonstrate that one way to achieve social justice and protect women is by promoting criminal and social justice reforms and legal changes.

The participants constructed the legitimate means for achieving policy reforms as being systematic policy evaluation, policy research, engaging with policy-makers, and promoting improvements. By framing their actions in these terms, they sought to legitimise their actions as more than mere interest-based politics. From the analysis of data provided, it was clear that in advocating for policy reforms, women's rights advocacy groups also proffer alternatives in the process. They even could go further by sponsoring the alternatives to ensure implementation. Seven of the women's rights advocates emphasised these goals.

Advocating on effective implementation of policies

More than half of the participants interviewed in this study indicated that there are many policy documents, guidelines, and laws but their implementation is a challenge. According to the participants of this study, if the policies exist but are not implemented, they are as good as not being there. They, therefore, apart from advocating for policy formulation, also advocate for effective implementation of existing policies to enhance service delivery. The implementation loopholes mentioned include lack of political will, inadequate funding or negligence, or a mixture of all the stated reasons. One of the roles of advocacy groups, therefore, is to bring the gap between policy and implementation to the attention of policy-makers for solutions. Women's rights advocacy groups therefore play monitoring roles to find out what aspects of the policy are working well at the implementation stage and otherwise. Their monitoring also looks out for resources that are not

sent on time for implementation. This reflects Dye's (2010) definition of policy as including what the government chooses not to do. Monitoring policy implementation focuses, not only on programming but also on resources. There could be cases, where the release of resources for the implementation of policies is delayed and this makes implementation of the policy difficult. Efficient use of resources is critical in the successful implementation of policies. There could be cases where the implementation of policies could experience challenges because funding was misapplied or inefficiently managed. When women's rights advocacy groups in this study identify such issues, they bring them to the notice of policy-makers and demand the efficient use of resources. Their advocacy therefore goes beyond seeking effective policy implementation to ensuring the whole political process is effective and accountable. The women's rights advocacy groups, therefore, undertake policy scrutiny roles on what the government chooses not to do or are not doing well and advocate for the government to act.

Generating Evidence from the Grassroots for Policy Change

Evidence-based advocacy was discussed in detail in chapter five, but the analysis in chapter four was also laced with the need for evidence in the advocacy process. An evidence-based discourse was constructed which provided insight into how these advocates understood being effective and persuasive in their actions. They knew policy-makers needed scientific evidence of a problem and they could not merely present human rights with moral arguments. Evidence is used in advocacy as a strategy and a framing for effect. Women's rights advocacy groups used data to show how the two genders are affected by particular issues they push on the agenda to make a case. Women come out as more disadvantaged in reproductive health and violence issues and hence provided the basis to push an agenda for women. Evidence on gender, therefore, became an entry point for advocacy. Evidence-based advocacy as a framing of the advocacy issue, implies women's rights advocates appealed to being scientific and objective to present their claims as 'rigorous and valid' (Storeng and Behague, 2014).

The advocates perceive evidence gathering is one of their main roles. Evidence was gathered through research and the work of advocates at the grassroots. Women's rights advocates are grassroots workers who have first-hand information on the problems of the people they represent. The emphasis on the grassroots activities by advocates indicated that it is not only public servants and professionals named by Lipsky (1980) who act at the grassroots, but advocates are also grassroots community actors performing roles as policy entrepreneurs (Klugman 2011). Advocates have a concrete basis for the policies they propose for formulation or amendments or enforcement of implementation. Working at the grassroots: district and community levels, allowed advocates to have primary data on reproductive health and violence against

women issues. This contrasts with the policy-makers who were presented as usually not in touch with the people though they were expected to have been. Through this possession of evidence by advocates, the women's rights advocates give justification to their role of representing the women. There is also data indicating that without this role of women's rights advocates, policy-makers would be formulating policies that could not meet the needs of the people. So, one of the advocates termed issues around evidence as “information politics”. Participants alluded that control over data is political and it gives the one who has it power in the policy-making process. The importance of evidence is again demonstrated that an organisation was set up primarily to research critical women's rights issues including violence against women to support advocacy actions. Without evidence, policy-makers accuse advocates of being sentimental and emotional about issues that may be non-existent. Advocates without evidence would not achieve their intended results. This is because policy-makers may trivialise the issues presented except, they see proof that a considerable percentage of the population is suffering and therefore it makes economic sense to invest in the issues raised. Data provide points of reference and also serve as the centre of discussions. The use of the data helps in creating a picture of the advocacy issues and aid in getting responses.

Evidence employed by the women’s rights advocacy groups included both quantitative and qualitative data. The groups, in addition to existing data, also presented the people who are affected to tell their own stories during the advocacy process. This is an expression of Wessel’s (2018) position that qualitative inquiry uncovers aspects of social realities not available in quantitative inquiry. The narratives provided by the affected communities and target groups give in-depth information on the problem on the agenda. The evidence, therefore, gives a face to the advocacy issue presented. The women’s rights advocates also gathered data through reviewing policy documents, implementation of policies, and news in the media. Some advocates assert that the emphasis on the need for data gathering by advocates reveals that the government itself does not have adequate data on reproductive health issues and where data existed, it was not accessible by advocates. The data was also not disaggregated into regions and districts. The collation of various forms of data at various levels is a challenge and hence accessing useful data, is difficult. But in a decentralised government system discussed by Mayhew (2003), it is expected that at the regional and district levels, data would be available and accessible. This gap in accessing national level data influences and shapes the perception of the role played by women’s rights advocacy groups in bringing up evidence from the grassroots. Evidence was used to generate information materials and policy briefs for various advocacy activities and strategies. There are arguments that often research findings are simplified and gaps in research evidence are not thoroughly acknowledged in the advocacy process and that evidence-based framing can also include over-generalising from small-scale studies to present cases to policy-makers. Irrespective of

this stand, women's rights advocates of this study indicated that evidence-based advocacy is important in framing advocacy issues to provide accurate policy direction.

8.1.3 The strategic and entrepreneurial nature of women's rights advocacy in Ghana.

The evidence from the research indicates the strategic and entrepreneurial nature of the women's rights advocates and their groups as they work throughout all aspects of the policy-making process in Ghana. Participants of the study were committed, resourceful, collaborative and strategic in influencing all aspects of the policy process and promoting change. The groups took advantage of windows of opportunities that opened in the policy arena and strategically pushed agenda items for policy-making in the areas of reproductive health and gender-based violence, proffering solutions to the problems.

The participants promoted ideas by constructing legitimate means for achieving policy reforms; systematic policy evaluation, policy research, engaging with policy-makers, and promoting improvements. By framing their actions in these terms, they also sought to legitimise their actions as more than mere interest-based politics. It is also clear that in advocating for policy reforms, women's rights advocacy groups also proffer alternatives in the process. They even could go further by sponsoring the alternatives to ensure implementation.

Difficulties in obtaining funding for women's reproductive health issues and violence against women were mentioned as a challenge for advocacy in general. Inadequate funding affects advocacy by making women's rights advocates sometimes, pursue projects because they are the priority of the donor but not because the country necessarily needs such projects, at least, from their perspective. The effect of donor funding on health and related issues are well documented by Asante and Zwi, (2009). As policy entrepreneurs, women's rights advocacy groups recognised inadequate funding for advocacy actions especially since the year 2000 and the thesis evidenced their innovation to overcome funding challenges by investing time and resources in their advocacy actions. Women's rights advocacy groups, apart from writing proposals for advertised calls for expression of interest, also integrate reproductive health into their relevant projects and some even fund advocacies from their own earnings.

The participants demonstrated that inadequate funding affects advocacy by making women's rights advocates sometimes pursue projects that may not be their priority nor the priority of the country, but rather priority of donors. By this, the women's rights advocacy groups as policy entrepreneurs increase their legitimacy by making resources available for reproductive health policy-making. Coalition building was

strategically pursued to pool resources - both funding and skills together. When advocacy funding of a member ends, another member also provided funding to continue the advocacy process. The data analysed also showed that apart from funding, coalitions helped these policy entrepreneurs mobilise human resources like drafting of legal instruments, administration, advocacy and evidence gathering for the advocacy process.

Coalition members take advantage of the presence of members in other districts, regions, and towns where they don't even have offices to scale up projects and implement them as they use other members to implement their activities. By so doing, distance, lack of office and staff by one member do not become limitations to pursue advocacy since other coalition members offer their space and personnel to support advocacy projects by other members. These findings resonate with Apusigah, Tsikata and Mukhopadyay (2011) assertion that networks are significant in the policy-making process. Coalition was also primarily used strategically to build a stronger voice and movement to be heard by policy-makers because coalitions bring on board numbers for the advocacy action, including the voices of the affected communities.

One of the innovative ways the women's rights advocates used in pushing their agenda and working at all levels of the policy-making process is framing of their messages. Advocates perceive framing as categorisation and proper packaging of advocacy messages to provoke the needed response (Entman, 1993). Though the women's rights advocacy groups frame in diverse ways including reproductive health as women's rights, human rights, and some did multiple framing including child rights, the dominant framing was "gender". Gender was the keyword and a strategic term around which women's rights advocacy groups framed their advocacy messages on reproductive health. According to them, gender connotes inclusion, and hence policy-makers respond to such framings. When advocates began their advocacy with gender it gave comparably easy access to the minds of policy-makers, who are predominantly men. Gender was appealing because the policy-makers (who were mostly men) also found their needs being taken care of and hence respond adequately to such framings. The above evidence confirms the negative impact of the low representation of women in the policy-making realms as stated also in FAO's report (2012). It raises issues on gender stereotyping and how culture influences how men think of women.

Many of the sample population did not want to be known as feminist. Only one of the participants identified herself as a feminist and all advocates said they did not frame their issues as feminist. It was evident also that policy-makers were not receptive to feminist framing. This position is not unique to the Ghanaian political landscape as Moses (2012) demonstrated that the term "feminist" has meant different things to

different groups of women and politicians in history. Feminists had been associated to enemies of the struggle against capitalist and imperialist ideologies of the West and feminists have also been portrayed as sexist, unhappy women, and haters of men. Goldberg calls for the need to reconsider feminism for the various women's activism because of its numerous advantages of a global identity movement and reinvigorating the success of the feminist movement.

8.2 Reflections on Methods

While there are studies on women's rights advocacy groups, many of these studies have not focused on women's rights advocacy groups' perspectives of their roles, especially from the angle of formulation and implementation of policies. A qualitative interview was employed so that in-depth experiences and knowledge of the women's rights advocacy groups could be gathered as they reflect on their roles and that of their organisations in the policy-making process in Ghana. The interview guide for each of the sampled participants' categories: leaders of women's rights advocacy groups, policy-makers, and UN workers, helped in getting views of reproductive health policy formulation and implementation in Ghana from the angles of different policy actors and how violence against women, which is one of the determinants of women's reproductive health, is pursued in the agenda-setting and policy-making process. The views of policy-makers, in many instances, clarified the perspectives of women's rights advocacy groups and highlighted the political environment in which they work. The role of the UN agencies in social policy-making and implementation in Ghana is unearthed as the sampled participants of this study demonstrate that their agencies provide technical and sometimes funding support to the advocates. This endorses literature that for a developing country like Ghana, international politics and organisations affects national-level policies.

Though the perspectives of the sampled population provide rich insight, they do not in any way claim generalisation of the results and hence the results cannot be said to be a national trend. Initially, the researcher had planned to employ mixed methods, using a questionnaire to gather quantitative data in addition to the interviews. But it was difficult to get numbers that make the quantitative data useful. Future studies therefore could consider a mixed method to bring on board data that can be generalized. Irrespective of the challenges stated above, the rich insight gathered through interviews is useful since the sample population have experience and interacted with other policy actors both locally and nationally, and they bring various perspectives to bear on the topic.

Combining the agenda-setting theory of Kingdon (1984) and the Gender theories on inequality provided a suitable framework for analysis of social policy-making processes by women's groups, who primarily construct their roles as achieving policy and social change through the promotion of reproductive health and the rights of women. Kingdon's theory on agenda-setting allowed the discussion of policy-making processes and how, as policy entrepreneurs and hence policy actors, women's rights advocacy groups seize windows of opportunities and push items on the policy agenda. The theory provided the framework to explore policy change, framings, the policy processes and the interaction among actors. But the theory could not provide a framework to examine women's rights which is important to this study especially when reproductive health and gender-based violence are key concepts. Gender theory of inequality therefore became a complimentary framework to discuss women's reproductive health issues and gender and policy implications. The two theories then, offer an opportunity to fuse the two major concepts of this study (policy-making and women's rights) to arrive at the research findings and conclusion. It is important to carry out further research on feminist framing and its implication in the Ghanaian advocacy environment and investigate the implications of the over-dependence of the concept of gender as a starting point in the framing for advocacy on women's reproductive health and violence against women.

This research had a specific focus on the perspectives of women's rights advocacy groups in the policy-making process in Ghana. The research could have also asked questions about how their personal experiences as women and as part of the cultures they work in motivate them in their advocacy work. This area could be pursued to find out how the private experiences of women affect their public lives and its implication for the advocacy process.

There were challenges also with studying as a remote location student and combining the studies with work. Usually the time to get exclusive study period was when I travelled to Sheffield for supervisory purposes, then I could use the physical library also. During the COVID period, visiting Sheffield was held up for over a year and a half because of international travel restrictions and University of Sheffield policies/guidelines.

8.3 Policy implications

A significant issue around representation is the voices of the affected communities/people in the policy-making process in Ghana. Women's rights advocacy groups could continue to explore strengthening the voice of the grassroots people to ensure their active participation in advocacy. Through the data analysed, it was evident that affected communities are engaged at some levels, but it is only one advocate whose definition of advocacy encompasses the voices of the grassroots people and hence demonstrate participation

throughout all the processes. It should be possible to make the inputs of affected communities a requirement in the policy-making process to ensure that policies are made by and with affected communities.

Availability of data and accessibility by women's rights advocates is critical in providing evidence for advocacy demands. The heavy demand and reliance on evidence for advocacy in Ghana implies the need for robust data at the national and regional levels for use by advocates. Their data presented and analysed showed efforts by women's rights advocates to research their areas of operations and to bring evidence from the grassroots. But their need as expressed, is also robust national level data disaggregated at the regional and district levels which could be easily accessible by women's rights advocates. Though one group was solely set up to engage in research and provide evidence to women's rights groups, the discussion on funding challenges demonstrate that many of the groups may not be able to fund studies on a large scale. Government should have interest in ensuring that data is available on reproductive health and violence against women so women's rights advocates and other interested practitioners could access them to guide their work and also to inform policy formulation and implementation. Access to national, regional and district level data from government agencies is necessary to actualise the construction of their roles.

Coalitions that are loose (not registered networks) usually become weak after the achievement of the main advocacy objectives. However, the evidence advanced by sampled participants indicated that there are also many issues that require advocacy at the implementation level, and hence the activeness of advocacy groups needs to be maintained for continued engagement for smooth implementation. But to achieve this, the availability of funding for women's rights advocacy groups needs to be considered by both in-country funders (Ghanaian) and international partners. Advocacy is a long-term activity and hence suitable long-term funding is required for meaningful engagement and the survival of women's rights advocacy groups.

8.4 Research Development in Women's Rights Advocacy Groups and their roles in Policy Formulation and Implementation

Further research into the dynamics of relationship between advocates and other policy actors will be necessary. Three out of the six policy-makers asserted they also do advocacy at various levels. Their interaction as policy-makers with women's rights advocates and their roles sometimes as advocates need further enquiry. At what time do they play each role, what motivates them in switching to become advocates, their target of policy actors, among others, will need to be investigated further.

The findings of this study indicate that many women's rights advocates do not frame their issues as feminist and only one of the sampled participants identified herself as a feminist. This development will also need further research especially regarding its implication for advocacy on women's rights. The overdependence of "gender" framings and its effects on the policy-making on women's sexual reproductive health and rights and violence against women should be investigated further.

Dwindling of funding for advocacy on women's reproductive health and violence against women was well discussed by participants of this study. This phenomenon could be further researched to unearth the causes,

Four out of the 16 women's rights advocates interviewed were men, evidencing that some men pursue women's rights. A further enquiry into men as women's rights advocates would be useful as it could explore men as collaborators, pursuing policy change, changing men and boys and enhancing their role in women's reproductive health and reducing gender-based violence.

Lastly, the findings established that traditional leaders, religious leaders and culture play key roles in women's reproductive health and violence against women in Ghana. These emerging themes need further investigation to establish the level traditional leaders could be involved in the advocacy process, the roles they could play and the effect of their actions or inactions on the rights of women.

8.5 The contribution to Knowledge of the Thesis

The thesis makes key theoretical and empirical contributions to knowledge of the reproductive health policy-making process in Ghana and the perceived role of women's rights advocacy groups. One set of findings provides insights into the broad and highly strategic role women's rights advocates play in this policy context and field. A second set of findings indicates the complexity of the international-national dimensions to healthcare policy-making and advocacy in Ghana.

Several of the study's findings challenge an assumption often found in literature about advocacy groups that emphasise their key role in relation to the agenda-setting phase of the policy process. In this sense advocates are viewed as campaigning to place issues on the policy agenda and to propose certain 'policy solutions' to these (Joachim, 2003). However, in this thesis, a broader role played by women's rights advocacy groups has been evidenced. This is related to my sample including advocates with law expertise seeking to advance legal protection for domestic violence. In chapter 5 for example, the women's rights advocacy groups studied for this thesis demonstrated that they go beyond the traditional role of advocates and draft legislative instruments for the government's consideration and work on these instruments together with government

ministries and agencies. Another example of such a role evidenced in this thesis showed that women's rights advocates with reproductive health backgrounds draft and review training manuals for government health training institutions and fund the production of such manuals. Thus, my study generated evidence that in comparison to the UK context, the separation between campaigners and 'civil servants' was not as stark; and that an activity like drafting legislation was seen as a necessary role for advocates to achieve policy change.

Secondly, the concept of policy entrepreneur helps to provide insights into the strategic ways advocates operate and influence policy processes as participants of the policy process (Kingdon, 1984). The sample of advocates interviewed in this study indicated that as policy entrepreneurs, they bring their professional skills of law, medicine, media and advocacy to bear on the advocacy process. In Chapter 5, when discussing their role in the advocacy process, the women's rights advocacy groups of this study highlighted that they draft policies and bills. In Chapter 7, the participants of this study as policy entrepreneurs, pull resources together as they take turns to fund ongoing advocacy actions. They use their own funds when donor funds are inadequate. Sometimes, they strategically frame their advocacy actions to enable them to integrate reproductive health advocacy into other projects and thereby sustain their advocacy actions. This highlights the diverse skills, resources and strategies that women rights advocacy groups employ in Ghana to influence policy-making. Perhaps, if the study was about a different area - there may be different findings, or the skill-set demonstrated by advocates may differ.

The third key contribution this thesis makes to knowledge is the recognition of the advocacy groups of the bottom-up approach to policy-making and how they engage women's groups and communities at the grassroots in the advocacy process. This thesis demonstrates the various ways women's rights advocacy groups sampled for the study engage with the people and communities they represent to bring communities' voices to the policy-making process through advocacy and how evidence generated is key in promoting a bottom-up approach to policy-making.

Empirically, the thesis highlights the high level of demand for evidence by policy-makers during the advocacy process in Ghana and its impact. In chapter six, women's rights advocacy groups highlight that they are usually under pressure to produce evidence during the advocacy process. This is against the background of the unavailability of data from government institutions on women and reproductive health and rights issues. A whole organisation was therefore established by women's rights advocacy groups to do research and bring up evidence for advocacy on violence against women and how it impacts women's lives including their reproductive health. Women's rights advocacy groups gather primary data from their

beneficiary communities, and they bring the communities to the advocacy platforms to speak about the issues that affect them. As the groups do this, they perceive their role as generating evidence for policy-making. The women's rights advocates also demonstrated that the policy actor who controls information/data has power in the policy-making process and hence access to data gives women's rights advocacy groups power as they control the 'infopolitics' during the policy-making process.

Fourthly, the evidence generated from this study suggests that the women's rights advocates framed their advocacy actions and messages in different ways, and these were affected by the gender inequality based on culture. Some preferred to use children's rights or health framing to appeal to wider policy elites. The women's rights advocacy groups indicated a strong hesitancy in using the word 'feminist' and inclined more towards employment of the word 'gender' as framing: it was found more acceptable by policy-makers since it is perceived as more inclusive. This raises questions on the effect of the framings which are tactfully or strategically taken up and the outcome of advocacy actions. This finding links well with the feminist critique of children's rights and social investment in international policy discourses that they can marginalise gender inequality issues and politics.

The fifth contribution to knowledge of this thesis is the evidence of the engagement of traditional media in the policy-making process in Ghana and the low level of social media engagement. Women's rights advocacy groups work with the media to raise awareness of the advocacy actions and seek for support from the masses. The media also helped in reaching policy-makers asking for their views and the need to act on advocacy issues. However, both the literature and data analysed indicate low usage of social media in comparison to how social media is employed in developed countries for advocacy. Though the research did not focus on social media, its absence in the responses of participants is indicative that it was not crucial in media advocacy at the time of data collection for this thesis. This is one of the areas that further research could focus on.

Lastly, evidence generated indicates that the donor community, mostly from the developed world, either through the UN bodies, bilateral organisations or private donor institutions, are highly influential in policy-making on reproductive health and violence against women and advocates strategically appeal to their priorities and programmes. Several studies and scholars have evidenced the influence of supranational political and economic institutions on policy-making in developing economies (Hill and Irving, (2020). However, few studies have examined how these institutions affect policy-making through advocacy and in Ghana. This thesis has provided in-depth insights into how advocacy groups recognise these institutions and

how these institutions operate in Ghana and through which mechanisms they influence policy-making. As advocacy actions are largely funded by international institutions (reflecting how the reproductive health of the nation is also funded), women's rights advocacy groups work in areas where funding is available. This raises concerns about advocacy actions being restricted and skewed towards donor interests.

8.6 Concluding Thoughts

This research has explored the perspectives of women's rights advocacy groups in the reproductive health policy-making process in Ghana and how they construct these roles to achieve policy and social change through the pursuit of the protection of the rights of their target beneficiaries. The women's rights advocacy groups of this study provide legitimacy for their roles as being grassroots participants in the policy-making process and hence provide evidence from the "bottom" (grassroots level) to the "top" (national level) as they amplify the voices of the vulnerable groups they represent. The groups seek policy and social change and pursue social and criminal justice through policy formulation and monitoring of implementation. In pursuing these roles, women's rights advocacy groups adopt strategies through framings, evidence generation, and monitoring of implementation. They have engaged in non-traditional advocacy roles such as funding advocacy outcomes (developing and printing training guidelines proposed) and drafting bills. For women's rights advocacy groups to continue to be effective, coalitions and their dynamics need to be well managed to continue to yield benefits to the advocacy process. Their engagement with policy actors at various levels and with funders is critical in achieving policy and social change. Access to sustainable funding is needed in maintaining a strong advocacy front to ensure the rights of women are upheld.

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Appendix 1

DEPARTMENT OF SOCIOLOGICAL STUDIES

Researcher: Nancy Ansah

P. O. Box DS 1636, Dansoman, Accra, Ghana

Telephone: 00233 (0) 244164386

Email: nansah1@sheffield.ac.uk

INFORMATION SHEET

Reproductive Health Policy Formulation and Implementation in Ghana: The Role of Women's Rights Advocacy Groups

Invitation to participate in my PhD research

I would like to invite you to participate in my research which examines the aims, activities and impacts of women's rights advocacy groups in developing reproductive health policies and provisions in Ghana. I am completing this study as part of my PhD studies [August 2014-August 2020] affiliated to, and supervised by, the Department of Sociological Studies at the University of Sheffield, UK. This information sheet provides you with comprehensive information about my study, why I have invited you to participate and what taking part involves. Please read the information provided below and do contact me if you would like to ask any questions about taking part in the study with me further before you decide to take part.

PhD study aims

The aim of the research is to explore the types, aims, activities and impacts of women's rights advocacy groups operating within the reproductive health policy sector in Ghana. Informed by international research about the significance of advocacy movements in social policy processes as well as gender inequality theories and studies – the study is particularly interested in exploring the relationship between women's vulnerabilities to violence and its effects on their reproductive health, and advocacy actions of women's rights groups and organisations in relation to these issues. Through qualitative interviews and a survey, the study will examine:

- The aims, objectives, perspectives, activities, strategies and impacts of women's rights advocacy groups in relation to gender-based violence and its impact on women's reproductive health and reproductive health policy developments.
- Explore the aims, nature and impacts of collaborations and relationships between women's rights advocacy groups in these areas.

Research approach and data collection methods

Participants of the research are leaders of women's rights advocacy groups, policy-makers and representatives of UN groups who work in the area of reproductive health and/or gender. You have been chosen to be part of this research because you are a leader of a women's rights advocacy group or you are a policy-maker in a ministry or agency which has responsibility for women's reproductive health or violence against women. You may also be a representative of a UN group that funds or supports reproductive health and gender issues in Ghana.

My study involves two main methods: a survey and qualitative interviews. A questionnaire consisting of 62 questions will be used to gather data for the survey and this will be filled in by leaders of women's rights advocacy groups. The questionnaire will gather data on the number of advocacy projects in reproductive health and violence against women which the advocacy groups have implemented in the past decade and half, the aims of the advocacy activities, which organisation(s) fund the advocacy activities, the triggers of the advocacy activities, the size of coalitions during such advocacy actions, the nature and type of other policy actors and the role of each of these actors in the advocacy process, advocacy tactics employed, and the outcome.

It is anticipated that you will use 20 minutes to fill in the questionnaire. The questionnaire can be filled in at your own pace (within a month) and returned to the researcher.

The qualitative interviews seek to solicit in-depth information on the above questions and especially provide data on how the groups set the policy agenda and frame the issues and the possible solutions they offer. It will also explore how these framings (feminist/gender /reproductive health/violence against women/women's rights) affect the outcome of the advocacy process. The interviews will also include the nature of interactions among policy actors. You will be asked to share your experiences on the advocacy processes and how advocacy outcomes were achieved.

Policy-makers and representatives of UN groups are the usual targets of advocacy actions. As a participant in this category, you will be interviewed on the frequency of women advocacy activities in which you are involved, your assessment of the effectiveness of women groups' engagement, the factors that make some groups more appealing than others, why some issues presented by advocacy groups are better received than others, how you lobby your colleagues to consider the advocacy issue(s), what you think could have been done differently, whether the advocacy activities had any effect on policy and why did change occur if it did.

Interview session is expected to last for about an hour. The researcher will ask that the interview takes place in your office, unless you indicate another venue of preference.

The researcher will collect data between January–September, 2017. Your interview date will therefore fall within this period.

What are the possible advantages of this research to me?

This research may provide an avenue for your organisation's advocacy activities to be documented if you choose that your organisation's name should be mentioned. It is also envisaged that there will be publications from the research in peer review journals, in which case if your organisation's name is mentioned (if you decide so), the academic community and other advocates around the world may read about your work.

What are the possible disadvantages of participating in the research?

No disadvantage to your person or organisation is envisaged. Your responses will be kept confidential and will not be linked to you unless you indicate on the consent form that you want your name or group's/organisation's name to be mentioned. Data collected will be kept in a secured place. The researcher intends to do an audio recording of the interview for data transcribing purposes only if you give your consent. The tapes will be kept secure in a locker and destroyed immediately after my PhD studies.

Do I have to take part? What will happen if I take part?

Should you decide to take part in this research, you will be given a consent form to sign. You can also withdraw from the research at any point if you so desire.

Potential Concerns

If you have any concerns with the data gathering processes during the research you may contact my supervisor:

Dr Harriet Churchill

Lecturer in Social Work

University of Sheffield

Department of Sociological Studies

Elmfield Building, Northumberland Road

Sheffield

S10 2TU

Tel: 0114 222 6440

Email: h.churchill@sheffield.ac.uk

Who is funding this research?

The research is being funded by the researcher and her employers.

Has the research project been reviewed by any ethics committee?

This research project has been ethically approved via the department of Sociological Studies review procedure of the University of Sheffield.

What will happen to the results of this research project?

The results of this research will be submitted as my PhD thesis at the University of Sheffield, UK. It may also be published in peer review journals.

Information Sheet and Consent form

You will be given copies of the information sheet and the consent form to keep if you are contacted for interview.

Thank you.



Appendix 2

DEPARTMENT OF SOCIOLOGICAL STUDIES

SEMI-STRUCTURED INTERVIEW GUIDE FOR LEADERS OF WOMEN'S RIGHTS ADVOCACY GROUPS

Title of Research Project: Reproductive Health Policy Formulation and Implementation in Ghana: The Role of Women's Rights Advocacy Groups

Self-introduction and introduction of research

Name, the purpose of research

I would like to confirm your consent for this interview and would be glad if you could sign a consent form for me. I would also like to seek your consent or otherwise for me to record the interview.

RESEARCH AIM

The research aims to explore the types, aims, activities, and impacts of women's rights advocacy groups operating within the reproductive health policy sector in Ghana. Informed by international research about the significance of advocacy movements in social policy processes as well as gender inequality theories and studies – the study is particularly interested in exploring the relationship between women's vulnerabilities to violence and its effects on their reproductive health, and advocacy actions of women's rights groups and organisations concerning these issues.

Your responses will not be linked to you and your name will not be mentioned anywhere in the research.

I would need one hour of your time for the interview.

SECTION A – About the interviewee and her/his organisation

1. Can you tell me about yourself and how you joined your organisation?
 - *What is your professional/advocacy background?*
 - *What motivates you to do the work?*
2. What are the aims, and activities of your organisation?
3. Let us discuss your advocacy activities - aims for the advocacy you do, what the objectives of the advocacy activities are and how you get money to implement your activities

Section B –

The link between violence against women and women’s reproductive health

4. **How prominent have advocates positioned the issue of violence against women in reproductive health advocacy?**
 - *Has this been an important issue in reproductive health advocacy?*
 - *What are the main issues for women? What are the main areas of concern you seek to raise awareness about? What should be done in your view? What are the main priorities etc?*

SECTION C -

The aims, objectives, nature, and influence of advocacy groups in Ghana

5. How do you see your role in national policy formulation and implementation changes?
 - What would you say are the main aims of advocacy groups as a whole - in raising issues, and promoting women’s rights
 - do you research alternatives and promote specific ones? Why? Which ones?
6. How do you present your advocacy issues to policy-makers?
 - feminist/gender /reproductive health/violence against women
 - How does the framing of issues (gender, health, human rights, feminist) affect the outcome of the advocacy process?
7. Why do you think these should be adopted? How will they improve women’s reproductive health?

SECTION D -

The Dynamics Involved in the Interaction between Advocacy Groups in the Coalition

8. I would like to ask you whether you join coalitions sometimes for advocacy activities. Maybe you can name some coalitions you joined and the advocacy action they carried out.
 - Who are the main groups, individuals, etc. you work with? Other NGOs? Which ones and Why? Do you work with international partners? Which ones?
9. How is the interaction among coalition members?
 - Did some play key roles more than others?
 - Were some positioning themselves as more important?
 - What made groups behave the way they did?
 - How important is coalition-building in the advocacy process?
 - What are the positives and challenges of coalitions in the advocacy process?
10. Which policy-maker/s did you consider the most important ally and why? How was their relationship with the coalition?

SECTION E -

Strategies/Tactics Used and the Outcome of the Advocacy Action

11. Please could you discuss the tactics (strategies) used by advocacy groups to achieve advocacy outcomes and which are effective and which ones are not effective?
12. Were the advocacy aims achieved and what were the key factors that influenced the outcome?
 - What were the aims of the advocacy action?
 - How will the achievements be sustained?
13. Which conditions were critical in determining the success or failure of the advocacy process?
14. Which advocacy activity of your organisation would you consider a big failure and in your opinion why did it fail?
 - Given another chance, what will you do differently to make that advocacy work?

Thank you.

Appendix 3



DEPARTMENT OF SOCIOLOGICAL STUDIES

SEMI-STRUCTURED INTERVIEW GUIDE FOR POLICY-MAKERS AND UN REPRESENTATIVES

Title of Research Project: Reproductive Health Policy Formulation and Implementation in Ghana: The Role of Women's Rights Advocacy Groups

Self-introduction and introduction of research

Name, purpose of research

I would like to confirm your consent for this interview and would be glad if you could sign this consent form for me. I would also like to seek your consent or otherwise for me to record the interview.

RESEARCH AIM

The aim of the research is to explore the types, aims, activities and impacts of women's rights advocacy groups operating within the reproductive health policy sector in Ghana. Informed by international research about the significance of advocacy movements in social policy processes as well as gender inequality theories and studies – the study is particularly interested in exploring the relationship between women's vulnerabilities to violence and its effects on their reproductive health, and advocacy actions of women's rights groups and organisations in relation to these issues.

Your responses will not be linked to you and your name will not be mentioned anywhere in the research.

I would need one hour of your time for the interview.

SECTION A- BACKGROUND OF INTERVIEWEES AND GENERAL RESPONSIBILITY OF THE MINISTRY/AGENCY ON REPRODUCTIVE HEALTH

15. Can you tell me about yourself and how you joined your Ministry or agency/caucus in parliament?
- *What is your professional background?*
 - *What are your roles in your Ministry, etc?*
 - *What motivates you to do the work?*
16. What are the aims, activities of your Ministry/agency/caucus in Parliament?
17. What role does your agency/office play in national level policy-making process?
18. What are the main health issues that have engaged your agency/office/ministry/caucus's attention for advocacy activities?

SECTION B: REPRODUCTIVE HEALTH AND ADVOCACY

19. What are the main Reproductive health advocacy issues that have engaged your agency in the past decade?
- Which action have you pursued in relation to these issues?
 - Who are the main actors?
20. Which women advocacy groups are you aware of?
- What roles do they play in the policy-making process?
 - Do you work closely with any? How and why?
 - What advocacy actions were these women groups/NGOs pushing for?
 - What do you think of the collaboration between your agency and the groups?
21. How effective is their advocacy on the policy-making/implementation process?
- Were their advocacy actions successful if yes, what factors accounted for the success and why? If no, why not? Also how do you assess their success?
 - What makes some advocacy actions more effective than others? Why?
 - To what extent do you think the size of an advocacy organisation/coalition determine its influence on the policy-making process?
22. How do they present the advocacy issues? Gender focus/feminists/reproductive health/human rights? Why?
23. Do you have an example of an advocacy action that was effective?
- Why was it effective?
 - Do you have an example of an advocacy action that was ineffective?
 - Why was it ineffective?

SECTION C: VIOLENCE AGAINST WOMEN AND REPRODUCTIVE HEALTH ADVOCACY

24. What does the Ministry/agency consider to be reproductive health issues as it relates to violence against women in Ghana?
- *Why these issues?*

- What is the Ministry or agency doing about these issues?
 - *What are the policy/programme initiatives on these issues?*
 - *Why these policies and programmes?*
 - *What are the impacts of these policy and programme initiatives?*
25. With whom do you work to design and also implement policies on these issues and policies?
- Why these actors?
 - Are advocacy groups among your partners? Which groups and why these groups?
 - What are the specific roles of women advocacy groups in the policy-making process relating to violence against women and reproductive health?
 - What is the outcome of their participation on issues relating to reproductive health and violence against women?
 - What triggers the advocacy actions the groups embark on?
26. Please tell me about an advocacy action that influenced/has influenced policies on violence against women as it affects women's reproductive health?
- Why was it effective?
 - Who were the main actors?
27. Do you have an example of an advocacy action that was ineffective? Why was it ineffective?

Thank you very much. If you would like to add anything you may email me via Nansah1@shffield.ac.uk.

Appendix 4



DEPARTMENT OF SOCIOLOGICAL STUDIES

PARTICIPANT CONSENT FORM

Reproductive Health Policy Formulation and Implementation in Ghana: The Role of Women's Rights Advocacy Groups

PhD research by Nancy Ansah

Registrar, Regent University College of Science and Technology, Ghana

PhD student, Department of Sociological Studies, University of Sheffield, UK.

Email: nansah1@sheffield.ac.uk

Telephone: 00233 (0) 244164386

Participant Identification Number for this project:

Please initial box

1. I confirm that I have read and understand the information sheet explaining the research project and have had the opportunity to ask questions about the project.
2. I agree to take part in the above research project and I understand that my participation in the study is voluntary and I am free to withdraw from the study at any time without giving any reason.
3. In participating in the survey and interview for the study, I understand that my responses will be kept strictly confidential, and that recorded data will be kept secure.
4. I understand that my responses will be anonymised for use in any publications and reports related to the study unless I prefer my organisation to be identified in the study.
5. I agree that the interview with me can be audio recorded and I have been fully informed about how the recorded data will be kept secure and anonymised.

6. I am aware I can decline to answer any interview question or request the recording be temporarily paused if I would like to speak without being recorded.

Name of Participant

Date

Signature

Name of PhD researcher

Date

Signature

To be signed and dated in presence of the participant

One copy will be provided to the participant.

Appendix 5

PARTICIPANTS, THEIR MAJOR FRAMINGS (WOMEN'S RIGHTS ADVOCATES ONLY) AND BACKGROUND			
Serial Number	Pseudonym	Framing	Professional Background and Specialisation
1	Akosua	Multiple framing, gender	Advocate with Human Resource Background
2.	Grace	Gender	Gender Specialist and Social Work
3.	Ama	Gender empowerment	A Professor
4.	Linda	Multiple framing	Medical Practitioner
5.	Akua	Women rights	Advocate/trainer
6.	Emma	Gender, human rights	Journalist
7.	Harriet	Women's rights and gender	Legal Practitioner
8	Sandra	Gender	Sociologist
9	Felicia	Feminist	Advocate
10.	Aseda	Women's rights advocate	Advocate
11.	Yvonne	Women's rights Gender, gender-based violence	Social Worker
12.	Kiki	Reproductive Health	Advocate
13	Mercy	Gender	Trainer
14	Idris	Child rights	Reproductive Health Advocate
15	Ikem,	Evidence, women rights	Doctors
16	Godfred	Specifics based on evidence	Political Science Background
POLICY-MAKERS			
PO1	Mabel		
PO2	Odo		

PO3	Yawa		
PO4	Dzifa		
PO5	Clara		
PO6	Kyereho		
UN REPRESENTATIVES			
U01	Augusta		
U02	Mary		
U03	Alberta		