

# Intersectionality perspective in practice?

A field study of intersectionality perspectives within  
Ghanaian NGOs' health work

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# Abstract

Intersectionality is becoming an increasingly important concept within gender research, emphasizing that social inequalities should be seen in the light of other identities than gender alone. The theoretical perspective, suggesting that identities interact and shape people's experiences and power positions, has also gained ground within the international community and development sphere. However, to what extent the perspective influences development organizations' work remains to be examined. The purpose of this study is to see if and how an intersectionality perspective is applied by development organizations working with women's health in Ghana, a country with great demographic diversity and health disparities. Using a case study method, two Ghanaian non-governmental organizations are studied, searching for views, approaches, strategies and methods related to the ideas of intersectionality. The material mostly consists of interviews with staff members and organizational and project documentation. The results indicate a generally broad recognition of women's intersecting identities causing different health challenges and positions. However, while some elements of the organizations' work seemed to be informed by ideas of intersectionality, most of their practices cannot be explicitly related to an intersectionality perspective. The perspective is most prominent within the organizations' strategies of inclusion and appears to be inspired by contextual knowledge.

**Key word:** intersectionality, NGOs, women's health, applications, approaches, strategies, methods, identities, discrimination, inclusion, participation

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# List of Abbreviations

CEDEP	Centre for the Development of People
ISODEC	Integrated Social Development Centre
ARHR	Alliance for Reproductive Health Rights
HAAP	Health Advocacy and Accountability Project
FRHP	Family Reproductive Health Programme
ARHP	Alliance for Reproductive Health Programme

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# 1 Introduction

## 1.1 Research Problem and Question

The notion that gender has to be seen in the light of other social identities which affect power relations has within feminist theory come to be called intersectionality. The concept of intersectionality has grown in importance among gender academics and practitioners in various fields and can also be explained as “an approach to understanding the relationship between gender, race and other aspects of identity that are sources of strategic discrimination”(Riley, 2004). However, while intersectionality can be described as an emerging new paradigm in gender studies and a crucial approach to reduce gender inequality (Degele and Winker, 2011), some mean that gender continues to be the identity through which injustice against women is seen within the development sphere (Lang and Porter, 2006 p.292). This notion raises questions of gaps between gender discourses and development practices, not least in contexts with diverse demography. The increasing share of development organizations adopting gender approaches also makes it interesting to see in what ways and to what extent ideas of intersectionality are influencing them.

I have studied two Ghanaian non-governmental development organizations’ health work with regards to their recognitions of women’s intersecting identities and positions. Development organizations and civil society organizations in Ghana at large are influential actors in advocacy for rights and in national policy debates. Women’s health is furthermore a vibrant topic in Ghana as the country is aiming towards achieving the Millennium Development Goals in 2015. While Ghana has made progress in providing health service to the broader population, women’s health and maternal health in particular is lagging behind. Ghana is furthermore an ethnically and religiously diverse country and studies suggest that there are substantial health discrepancies related to geography, ethnicity, religion and age. Because of this, Ghana makes an interesting case for studying intersectionality issues.

My purpose of the study is more specifically to investigate how intersectionality perspectives are applied by Ghanaian non-governmental organizations (NGOs) working for women’s health and gender equality. In order to investigate the linkages between the theoretical perspective of intersectionality and the two organizations’ work I performed a qualitative case study in which I explored how the organizations recognize, mobilize and include women with different social, economic, ethnic and religious identities. Special attention was

given to the approaches, strategies and methods within their health work, in the area of sexual and reproductive health and rights in particular. The basis for my analysis is material gathered from interviews with staff members and affiliated project partners, from organizational and project documentation and from visiting some project activities on the field. Since intersectionality is more often used as an analytical tool than as a perspective shaping development organizations' work, my intention is that this thesis will contribute to the discussion about the role and utility of intersectionality and bring forward new insights from a local perspective. I also hope that the study will illuminate interesting aspects of the relationship between gender discourses and practices and of the challenges and possibilities of turning theoretical perspectives into practice.

**My research question is:** *In what ways are NGOs in Ghana applying an intersectionality perspective in their work on women's health?*

## 1.2 Disposition

The structure of this thesis is as follows: I will begin by presenting the theoretical framework and providing an overview of intersectionality as a concept, theoretical perspective and analytic tool. I will briefly present the historical emergence and spread of the concept and thereafter describe the role of intersectionality in this thesis. Next, I will give a brief introduction to women's health issues in Ghana, not least to illuminate its intersectionality dimensions. This is followed by a presentation of the two organizations, their health work in general and the projects which I primarily studied. I will subsequently give an account of my methodology and method by illuminating my scientific standpoint, the case study method and my study outline and process. In this chapter I will also describe my interviewing process as well as present and discuss my material and analysis strategy. The following chapter is the analysis which ends with a summary of my findings in which I will answer the research question. Finally, I will carry out a concluding discussion about my study and findings.



## 2 Theoretical Framework

### 2.1 The Concept, Theoretical Perspective and Methodology of Intersectionality

Intersectionality is a central concept within contemporary feminist thinking and has become a buzzword within gender research and the development sphere. Intersectionality in its basic meaning is “the mutually constitutive relations among social identities” (Shields, 2008 p.301) and denotes that women’s different identities, such as gender, race and sexuality interact (or intersect) and shape their experiences and power positions (Crenshaw, 1991 p.1242-1244). The concept has contributed with an important perspective to empirical studies of gender, not least by challenging the homogenization of gender and women as categories. By emphasizing that “gender must be understood in the context of power relations embedded in social identities” (Shields, 2008 p. 301), intersectionality illuminates that identities causing marginalization of various forms cannot be isolated from each other. Discrimination against women therefore appears in different configurations and in varied degrees due to various structures of inequality (Morley, 2010 p. 537). Intersectionality thus imply more than multiple discrimination, since multiple discrimination suggests that the discrimination occurs on all aspects simultaneously. Intersectionality on the other hand assumes that discrimination is not static and that a person’s different identities are subjected to discrimination depending on time, situation and location (la Rivière-Zijdel, 2009 p.34).

Identities most commonly mentioned in relation to intersectionality are class, race, sex, ethnicity, religion, age and sexuality. These identities or categories are said to interact by mutually strengthening or weakening each other and thereby inequality (Crenshaw, 1989). To exemplify, a Muslim woman in certain western contexts may not only be discriminated because of her gender/sex and her religion, but experiencing that the intersection of the two identities reinforces the discrimination of them, not least because of prejudices against such an intersection.

Controversies exist of whether intersectionality should be seen as a concept, a theory or an analytic tool (Davis, 2008 p.68). Feminist scholar Nina Lykke presents a broad definition which encompasses many dimensions of intersectionality. According to Lykke, intersectionality is a

theoretical and methodological tool to analyse how historically specific kinds of power differentials and/or constraining normativities, based on discursively, institutionally and/or structurally constructed sociocultural categories such as gender, ethnicity, race, class, sexuality, age/generation, dis/ability, nationality, mother tongue and so on, interact, and in so doing produce different kinds of societal inequalities and unjust social relations (Lykke, 2010 p.50).

Intersectionality can thereby be seen as an umbrella term, which can help reveal different sorts of relationships depending on the theoretical standpoint of the researcher (Ibid p.50-51). Methodologically, intersectionality can be used as a tool for analysis, advocacy and policy development of various kinds. Kimberlé Crenshaw, coiner of the concept, had the ambition to invent an analytic tool which resisted exclusion and discrimination of colored women. “Her point is that the situation of women of color becomes misrepresented by political initiatives that are built on conventional politics, founded around resistance to only one power differential“ (Ibid p.71). Such a tool could not only uncover intersections of inequality, but also the intersections on which positions of dominance and inclusion are constructed and materialized institutionally and discursively (Ibid p.56).

The Center for Women’s Global Leadership describes intersectionality methodologies as crucial in exposing “the ways multiple identities converge to create and exacerbate women’s subordination” (Berger and Guidroz, 2009 p.56). According to the Center, the methodology also conveys the heterogeneity of women’s experiences, needs, struggles, identification and situation. An intersectionality methodology could in their opinion mean analyzing the power differentials and relations as well as experiences of particular groups of people within a certain context. It could also mean analyzing how to implement appropriate policies which take these intersectionality issues into consideration (Ibid p.56). However, there are many different theories related to intersectionality and while most feminists “agree that gender has to be understood in some kind of interplay with other categorisations” (Lykke, 2010 p.52), there are ongoing debates about the theoretical and methodological approach of intersectionality. I have here distinguished some of the key conflict areas:

1). *Intersectionality’s emphasis on categories of identities.* Critique of social categorization is a common element within feminist research where classifications based on gender, sex, race, ethnicity, nationality, sexuality, class etc are said to universalize and essentialize identities and categories (Wong, 1999). Since categorizations can be seen as products of societal, political, economic and social processes there is furthermore a potential risk of legitimizing social hierarchies when emphasizing categories of identity (Lykke, 2010 p.45).

2). *Prioritization of categories.* This discussion concerns whether some intersections and power differentials are more central than others. The issue of prioritization is closely related to possession of power over the political agenda. Connected to this question is also the one of whether there should be an openness to the addition of previously missed or newly emerging social

categories or if some delineation of relevant intersecting categories is needed (Ibid p.50-52, 83).

3). *Possibilities of a global sisterhood*. Intersectionality is at times used to question a universal sisterhood agenda, because of its emphasis on women's different experiences, interests and positions. The importance of women's intersecting identities also makes some feminists reject a "global, feminist 'we'" (Ibid p.53).

While these discussions are ongoing, intersectionality has become a crucial concept for most feminists and an important perspective within the international community. The latter will be depicted in the next section.

## 2.2 The Emergence and Spread of Intersectionality

Intersectionality is sprung from an anti-racist and postcolonial criticism of the hegemonic feminism where race and ethnicity is invisible. The opinions that race, ethnicity and nationality intersect and mutually influence the position of power and subordination of women were brought forward by black feminists in the US. While their "explicit articulation of the concept" (Lykke, 2010 p.85) occurred in the late 1980s, the "theoretical endeavor" of intersectionality has been present within feminism long before that (Ibid p.85-86). Intersectionality has further been emphasized by postcolonial feminists who mean that western feminists have to be aware of their positioning and recognize the differences in interest among women, which are due to "geopolitical positioning, class structures, ethnicized and racialized mechanisms of exclusion and oppression" (Ibid p.53).

The ideas of intersectionality have also spread to the international community. In the Beijing Declaration (1995), which was the result of the Fourth World Conference on Women, the importance of addressing women's varied identities in the struggle towards gender equality and opportunities for women was noted. Governments were called to strengthen

efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their empowerment and advancement because of such factors as their race, age, language, ethnicity, culture, religion, or disability, or because they are indigenous people (Beijing Declaration and Platform for Action, 1995).

Some also argue that intersectionality analyzes fit well with the growing adoption of rights-based approaches to development and gender issues. Joanna Kerr argues that "an intersectional analysis of identities such as race and gender can inform human rights approaches, particularly given perceived tensions between respect for diversity and recognition of the universality of (women's) human rights" (Kerr, 2001). The increasing interest in intersectionality issues within the international community was reflected in the UN Conference on Racism, Racial Discrimination, Xenophobia, and Related Intolerance in 2001. The conference

was held in South Africa and, together with the regional preparations, advanced the positions in terms of developing intersectionality approaches on the conference areas (Kingma and van der Hoogte, 2004 p.47). However, while there are recognitions of intersectionality in relation to women's discrimination within parts of the UN, proponents of intersectionality perspectives emphasize the need for development actors such as NGOs to recognize intersectional identities and adapt their work accordingly. Liesbeth van der Hoogte, advisor at Oxfam Netherlands and Koos Kingma, sociologist, mean that while the NGOs encounter people with multiple and socially determinant identities crucial to their everyday lives, they often work towards social change by challenging inequality based only on one aspect of people's identities. "This means, for example, that a project focusing on challenging gender inequality does not simultaneously work on challenging inequality between women from an ethnic majority, and women from an ethnic minority" (Ibid p.47). Furthermore, my findings of previous studies of intersectionality perspectives related to NGOs and their work has been scarce. Moreover, I have come across very few NGOs officially stating that they use intersectionality approaches or perspectives. This reinforced my interest in studying the two Ghanaian NGOs more up close on this matter.

## 2.3 Intersectionality in this Study

As depicted above, intersectionality is a theoretical perspective as well as an analytic tool. The focus of my study will be on intersectionality as a theoretical perspective. My study is furthermore an investigation of the applications of an intersectionality perspective among Ghanaian NGOs rather than an analysis of the patterns of power relations and intersectional inequality in Ghana. Since my thesis is not about carrying out a theoretical or methodological discussion of intersectionality as a concept, theory or methodology, I will not immerse myself in the different theoretical or methodological standpoints further. However, the conflictual context of intersectionality requires me to define what I mean by intersectionality perspective. My definition of intersectionality perspective, which will be the basis for my study and analysis, is *a perspective that takes into consideration that gender has to be seen in the light of other social categorizations and that interactions of these social identities shape power relations and social inequalities*. This definition of an intersectionality perspective is based on Lykke's broad one, and it could be said to not illuminate all aspects of intersectionality. Since intersectionality is a concept with various interpretations and dimensions, I wanted to work with a basic definition of an intersectionality perspective in this study. The complexity of the concept and the limitations of the case study method thus made me refrain from explicitly examining if the organizations applied an intersectionality perspective where it for instance is recognized that identities are mutually strengthening or weakening each other. It also kept me from searching explicitly for the intersectionality idea of

discrimination of women as dynamic rather than static, why this is not part of the definition either. However, this dimension of intersectionality can to a certain extent be found in the material and I will therefore return to it in the thesis' concluding discussion.

Intersectionality as a concept and theory assumes that intersections of identities are relevant in all contexts, why I do the same. I also assume that these intersections and their consequences, to some extent, are noticeable by the organizations and that they have to relate to them in one way or another. My analysis will evolve around central intersectionality concepts such as exclusion/inclusion and power differentials in terms of discrimination and stigmatization. Additionally, the organizations' recognition of the particularities in women's health experiences, interests and positions caused by their intersecting identities will also be analyzed.

While my search is framed by a theoretical definition and understanding of the concept of intersectionality, I am aware of the fact that my potential findings in terms of applications of an intersectionality perspective will not necessarily go under the name of intersectionality by the Ghanaian NGOs, just as similar ideas existed within feminism long before the term was coined. However, I am just as interested in finding out about the organizations' *usage* of the perspective and ideas of intersectionality as in their mere *knowledge* of the theoretical concept. I also acknowledge the fact that intersectionality is a complex theoretical concept, rooted in western academia and increasingly explored as an analytic research tool rather than as an approach or perspective shaping organizational work. My study's purpose can thus be expressed as seeing if and how an academic and increasingly popular gender perspective and its ideas are acknowledged on a local level through two Ghanaian development organizations working for women's health. My ambition is, as mentioned, also to see whether and how a complex and theoretical concept such as intersectionality can be turned into practice such as in approaches and strategies.

## 3 Background

### 3.1 Women's Health in Ghana

Recognizing the societal impact of women's health, Ghana has made a lot of attempts to enhance women's health situation. External and internal pressure has made Ghana take actions in terms of health insurance and free health care initiatives. Despite these efforts, issues of women's health are persistent as well as are the great health discrepancies among women throughout the country (Oxfam International, 2011, Kwapong, 2008 p.1, Aboba, 2011). Globally, as well as in Ghana, the fifth Millennium Development Goal (MDG) about maternal health is the one out of the eight which is furthest away from being fulfilled.

#### 3.1.1 Sexual and Reproductive Health

Sexual and reproductive health is central for women's general health situation in Ghana where maternal mortality is the leading cause of death among women in reproductive age. In 2003, 23.7 % of the deaths of women in this age were related to childbearing and between 2006 and 2010 the reported<sup>1</sup> maternal mortality was around 0,5 % (Kwapong, 2008 p.2, UNICEF, 2012). In 1994, complications of abortion were the most common causes of maternal death for adolescents (Baden et al, 1994 p.43). Teenage pregnancies, and especially unwanted ones, are thereby contributing to the high levels of maternal mortality. Among the commonly mentioned hinders for adequate maternal health are the low number of births attended by professional health personnel, the general lack of health personnel, cultural norms and lack of resources, information and infrastructure (Kwapong, 2008 p.2, Ghana Ministry of Health, 2011 p.10, Oxfam, 2011 p.7-8). Women's reproductive health is also comprised by the fact that while women are legally guaranteed freedom over their sexual and reproductive lives, socio-cultural perceptions of family life and gender norms limit these rights (Ghana Statistical Service, 2004 p.43-45).

Another threat to women's sexual and reproductive health is the relatively low but persistent HIV/Aids prevalence, in which women are greatly overrepresented

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<sup>1</sup> Reported maternal mortality refers to figures which are not "adjusted for underreporting and misclassification" (UNICEF, 2012).

(EnGenderHealth, 2012). People between 15-24 years accounted for 30 % of the newly infected with HIV in 2006 in Ghana, making young women particularly affected (ARHR, 2008 p.5). Since the country got independent in 1957, a number of policies, which serves to improve the reproductive health and “ensure that reproductive health rights and services are made available to the citizens without any form of discrimination by service providers or other citizens” (Ibid p.3), have been formed. However, stigma and discrimination is still following women and men living with HIV/Aids and continues to hinder people from accessing testing, treatment and therapy for sexually transmitted infections such as HIV/Aids (Ibid p.6).

In order to improve access to public health services, the Ghanaian government initiated a National Health Insurance Scheme (NHIS) in 2003. Since the introduction of the scheme, health has improved in the country. Nevertheless, the membership in the (to a large extent) tax funded insurance scheme is low and the majority of Ghanaians still pays for health care out of their pockets or acquire drugs and care through informal channels. The poorest are not surprisingly the ones least likely to register in the scheme (Oxfam International, 2011 p.8). Only a year after the NHIS introduction, a free maternal health care programme was established to tackle the issue of maternal mortality. The programme covered “normal deliveries; management of all assisted deliveries, including Caesarean sections; and management of medical and surgical complications arising out of deliveries” (Oxfam, 2011 p.7). However, due to lack of funding, the implementation was inconsistent. From being temporarily suspended, the free maternal health care policy was restated in 2008 with financial support by British aid. Both the NHIS and the free maternal health care programme have received critique for its uneven effect across the country and for not supporting the poorest. Furthermore, while some success has been made, for instance in the number of educated birth attendants, maternal deaths are in fact increasing in some of the poorest areas of the country (Ibid p.7-8).

### 3.1.2 Demographic and Geographic Disparities

Figures show that patterns of women’s health and access to health services are related to demography and geography. Overall, women living in the country’s northern region, in rural areas, with low education and low income are the most vulnerable in terms of health (Baden et al, 1994 p.43). Young women are also particularly vulnerable. Data reveals that mothers under the age of 20 are the ones least likely to be attended by a professional health worker (Ghana Statistical Service, 2008 p.16). The health disparities in Ghana are to some extent related to the uneven distribution of health workers in the country, “in favour of the more affluent regions, most of which are in the southern half of the country” (Ghana Ministry of Health, 2011 p.10). Access to and provision of reproductive health care is also greater in urban areas than in rural (Kwapong, 2008 p.2). Estimates of national maternal mortality rates reflect the differences in women’s health across

the country, ranging from 214 to 740 per 100,000 live births (Ghana Ministry of Health, 2011 p.17).

While one can make a cursory divide between the north and south of Ghana there are other dividing lines in the country where between 50 and 100 ethnic groups reside. Ghana has a Christian majority, around 15 % Muslims and additional percentages of the population belonging to traditional African religions (The Swedish Institute of International Affairs, 2012). Religion can affect health in many ways, one being presented in a Ghanaian study from 2003 showing that religious affiliation has a significant effect on women's knowledge about HIV/Aids (Takyi, 2003). No part of Ghana is ethnically or religiously homogenous, although some rural communities are demographically quite static. Some ethnic groups are nationally dominant by size and influence. Ethnic and religious tensions have occurred in modern time, although rather few during the last decades (Asante and Gyimah-Boadi, 2004 p.2, GhanaWeb, 2012). Other identities and factors shaping women's health in Ghana were depicted in Ghana Demographic and Health Survey of 2003. Among other things, women's lack of decision-making regarding their own health was studied and it was shown that the level of decision-making was highly related to the woman's age, marital status and economic independence (Ghana Statistical Service, 2004 p.43-45). Some groups of people are however difficult to find in health statistics. Information about health situations for people with different sexual orientations in Ghana is to a large extent absent due to homosexuality's criminal status and stigmatization.

## 3.2 CEDEP and ISODEC

The two NGOs I studied were *Centre for the Development of People* (CEDEP) and *Integrated Social Development Centre* (ISODEC). Both organizations work across the country, but I was mostly situated in ISODEC's main office in Accra (the capital city of Ghana), in CEDEP's main office in Kumasi (second largest city in Ghana) and in ISODEC's regional office in Tamale (a northern city in one of the poorest regions). CEDEP is a Ghanaian NGO with the ambition to support and build capacity among the vulnerable in order for them to fulfill their potential and achieve sustainable human development. The organization also seeks to promote social, economic and civil rights and to strengthen community participation and the voices of the marginalized. ISODEC is also a Ghanaian NGO, striving for social justice for all by advocating for human rights and promoting essential social services. The organizations' work has a strong focus on advocacy and policy change (CEDEP, 2012a, ISODEC, 2012). The two NGOs carry out work within several areas of development such as health and education. The organizations have been running since 1983 (CEDEP) and 1987 (ISODEC). They conduct their work in collaboration with diverse partners on the local, national and international level (Ibid). Most of the background information I gathered about the NGOs derives from interviews, documents and informal



conversations with staff members. Because of the mixture and multitude of sources, I will not refer to all of them in the text below.

A central partner is the Alliance for Reproductive Health and Rights (ARHR), in which CEDEP and ISODEC are the two out of three dominating NGOs. Both organizations cooperate with local NGOs in the geographical and thematic areas of their projects. Both NGOs' health work is primarily focused on sexual and reproductive health and rights with an emphasis on maternal health and HIV/Aids prevention. A gender perspective is mainstreamed into the organizations' core programmes and the organizations' health work is guided by rights-based approaches. The two organizations also share similarities in their working methods. Advocacy, community capacity building and awareness rising are among the most common methods used by both NGOs in their projects. ISODEC is however a slightly larger organization with a greater focus on civil society campaigns for policy changes than CEDEP.

The projects which I came to study closest because of their topicality and relevance were CEDEP's Health Advocacy and Accountability Project (HAAP) and ISODEC's Top project. The HAAP is a one year program with an overall aim to strengthen community members' ability to advocate for their own reproductive health rights and to demand adequate health care. The project is funded by a national organization called STAR Ghana and carried out by CEDEP in collaboration with the ARHR, the District Assemblies, Municipal Assemblies, Ghana Health service and its allies and local NGOs. The HAAP is a continuum of a previous project carried out by the ARHR which served to increase the "vulnerable's" knowledge about their rights in terms of reproductive health. The intention of the HAAP is to build community members' capacity in terms of advocacy skills and improve the participants' knowledge about current reproductive health issues. Meetings are thereafter facilitated by CEDEP where the community members can interact and discuss the pressing health issues and demands of their communities with the duty bearers in their district. The project is held in two districts in the Ashanti region, in Dormaa Municipality and in Sekyere East District.

The Top project is a community-based project aiming at improving access to maternal health care in rural areas in the northern regions of Ghana. The project is funded by Oxfam Great Britain and primarily implemented by ISODEC, with support from a number of other Ghanaian NGOs and networks and local NGOs affiliated to ISODEC (Oxfam, 2011 p.20). Many different kinds of activities are held on the local level with the main objective to "increase awareness and education of citizens rights regarding healthcare and enable women to demand their right to safe pregnancy and childbirth" (Ibid p.9). Among the activities are exchange of knowledge between traditional birth attendants (TBAs) and professional midwives whereby the TBAs, among other things, receive education and a cell phone to communicate with health facilities during complicated deliveries. There is also awareness rising, concerning women's health rights and the importance of seeking professional care, through activities such as drama performance, radio shows and door-to-door information. Each community in the relevant districts also forms a community health committee where crucial issues

of sexual and reproductive health and rights are addressed (Ibid p.5, 9-13). The project's local activities are also complemented by campaigns at the national and international level. These campaigns were however outside of my study scope and I will therefore not go into details.

The fact that the NGOs have foreign financiers of their health work and also carry out their work together with the Ghana Health Service and other NGOs is something I have kept in mind while studying the projects. I have put a lot of effort into distinguishing CEDEP's and ISODEC's implementation and perspectives from the ones of the local NGOs and foreign funders. During my stay at the organizations I participated in a couple of activities and meetings connected to their health work and projects. I participated in a community rally to demand improved health care delivery in Dormaa Municipality and an awareness rising meeting for the reduction of maternal and neonatal mortality in Offinso Municipality. Both these meetings were facilitated by CEDEP and part of the HAAP. During these activities I also got to interview a representative from the local partner NGO called the Centre for Maternal Health and Community Empowerment (CMCE). I furthermore participated in a weekly staff meeting at ISODEC's headquarter in Accra and in a meeting about a joint NGO action of advocacy for free health care, held by ISODEC. Because of illness I failed to visit the Top project activities, but I conducted a phone interview with a representative from ISODEC's local project partner NGO called Integrated Development and Health Centre.

## 4 Methodology and Method

### 4.1 Scientific Standpoint

The scientific standpoint of the study emphasizes interpretation as a means to acquire knowledge and understanding of the perspectives which guides the two Ghanaian NGOs' health work. Framing my study with a feminist theory also enables me to borrow a common feminist perspective on objectivity which emphasizes the embodied vision and situated knowledge of the scientist (Haraway, 2008 p.347-349). This means that my personal identity, characteristics and position cannot be separated from the knowledge I produce. It also means that my interpretations within this study take place from a specific active position and not from a passive void. This is not the same as claiming them to be totally subjective, but to recognize that "only partial perspective promises objective visions" (Ibid p.348) and that knowledge is situated (Ibid p.347-348). This scientific standpoint frames the study and its method, which will be elaborated below.

### 4.2 Why a Case Study?

My study has a qualitative focus and is in essence a case study. Case studies generally involve investigation and intense studying of few units in order to create greater understanding and draw conclusions about a phenomenon within a specific context (Yin, 1984 p.23). This method suits my qualitative research aim and purpose well since my intention has been to study two Ghanaian NGOs' health work with regard to their application of an intersectionality perspective. The case study method also fits well with my purpose of adding experience to previous research within the field of gender and development by empirical analysis (Ibid p.23).

Case studies do not aim at providing statistical generalizations or discovering universal truths but does not stand in contrast to generalization of theoretical propositions when carried out in a multiple manner (Yin, 2009 p.15). Because of this, I will not claim that my findings in these two NGOs are representative for other NGOs in other developing countries, or even in Ghana. I will nevertheless argue that my results can be an indicator of ways in which intersectionality perspectives are applied in the health work conducted by Ghanaian NGOs.

CEDEP's and ISODEC's national coverage, relatively great size and extensive relationships with other Ghanaian NGOs could be favourable in this aspect. The fact that both of them claim to adopt a gender perspective or policy could also make the study result into a relevant contribution to the understanding of the relationship between academic gender concepts and local development projects to improve women's health.

Instead of generalization; description and exploration is central to case studies. In order to acquire a comprehensive understanding of the particular situation, I have searched for information concerning the demography and health situation, in Ghana at large and in relevant regions. I have furthermore tried to get a picture of the current health challenges in terms of access and demographic barriers, from literature as well as from my interviews. This is also part of the case study process of "thick description", which involves "interpretation of meaning of demographic and descriptive data such as cultural norms and mores, community values, ingrained attitudes, and motives" (Colorado State University, 2012a).

### 4.3 Selecting NGOs

CEDEP and ISODEC were two of the great number of development NGOs within the area of health I contacted and asked to be part of my study. To get in touch with Ghanaian NGOs showed to be quite difficult and the two organizations were among the few which responded to my emails and accepted my request. During the process of contacting organizations I offered some of the bigger ones, which I believed were most likely to accept my request, to pay a small financial compensation for letting me conduct my study with them. However, neither in my email communication with ISODEC or CEDEP before the field study nor during my time there was the financial compensation mentioned by the organizations. I am also convinced that no one of the interviewees within the staff knew about my proposed compensation while participating in my study. I do therefore not believe that my financial compensation has had any effect on the study, but I mention this since financial contributions have the potential to complicate data collections and research results.

I recognize the possibility that the NGOs accepting my request to study this topic are more familiar and committed to the ideas of intersectionality than the ones who declined. The consequence of this selection could thereby be that the two Ghanaian organizations are not representative within the context. However, my belief is that the size and capacity of the organizations, the access and usage of internet as well as how accustomed they are to host international students and interns, are more likely explanations to their response. As demonstrated, CEDEP and ISODEC share some similar traits in terms of size, programme areas and project outlines. Even though my purpose has not been to compare the two NGOs, I see the benefits of having two somewhat similar and large organizations as study units. The similarities allowed my process of data collection to be quite similar for the two organizations.

## 4.4 Study Outline

Before starting the field study I had planned to perform interviews with staff members involved in the organizations' health work, with local partner NGOs co-complementing the health projects and with female beneficiaries within the project. I also planned to conduct a lot of participant observations while visiting the project activities. Because of irregular schedules for project activities, their location and illness from my side, my interaction with the field turned out to be less than I expected. This together with the time constraints made me focus more on the organizations' ideas and practices rather than the project implementation in the field. My visits to the project activities in the field were however valuable in terms of acquiring an understanding of the projects' outline and characters. They also enabled me to meet with representatives from local NGO partners as well as to speak informally with staff members from CEDEP and ISODEC.

While the time constraints made my usage of the typical case study methods less extensive than ideal, I have still touched upon all of them. These are interviews, participant-observations, field studies and protocol and/or document analyses (Colorado State University, 2012b). The strength of case studies lies in its ability to deal with many different kinds of material at once (Yin, 2009 p.11). Besides conducting interviews, I studied documentation and reports from the organizations' current and past projects. This was in order to broaden the picture of the organizations' work and views and trace signs of an intersectional perspective. Because of the little time I spent on the field, I can not examine the extent to which the organizations' attempts to have an intersectionality perspective are realized and actually implemented. Nor can I analyse the extent to which any realized attempts have been successful in addressing intersectionality issues. What I am able to do is to search for applications of an intersectionality perspective within the staff's recognitions and views, and within the organizations' approaches, strategies and methods as well as project designs.

While my stay in Ghana was limited, I tried to prolong the data collection by continue to communicate via email with the first organization while visiting the second one. I also dedicated one week in the end of my stay to do follow-ups of some interviews with staff members in order to get some things clarified or elaborated. The fact that I got a desk at both of the organizations and visited them daily also made it possible for me to have continuous dialogues with some of the staff members about their work. Besides handing in a short report on my findings at the request of both organizations, I have also enabled the NGOs' staff to read through and comment on the draft of the thesis before handing it in. These are measures which can also be considered beneficial to the study's reliability (Colorado State University, 2012c, Yin, 2009 p.41). A study has a strong reliability if errors and biases are minimized. Within empirical research, it is usually said that if this is the case, another researcher should be able to do the same study and data collection and end up with the same result (Yin, 2009 p.40). While errors in terms of misunderstandings during interviews (Esaiasson et al, 2004 p.67) cannot be completely avoided and while my scientific standpoint

rejects the notion of repeatable studies, I believe that a study's data collection can be more or less reliable. Besides returning to the interviewees with follow-up questions, some information given by the interviewees was cross-checked with several other sources of data and observations. Similar questions about the organizations' health work were also posed to different staff members to get certain facts or responses somewhat assured.

## 4.5 Interviews

Interviewing was the most central method of my case study. I used a semi-structured interview method in which I had a couple of basic interview templates, which I adapted to fit the different interviewees' positions and responsibilities. I usually followed the interview template quite well, but did many times deviate from the questions in terms of order and occurrence and often added other or posed follow-up questions. I got freer to deviate from the written questions the more interviews I conducted, something which might have caused the answers to change in character along the way. Most of my interviews were conducted with tape recorder, but the interviews during field visits or over the phone were of practical reasons not recorded. I did not use an interpreter since most of the interviewees spoke English quite well.

I could not plan any interviews before arriving in Ghana and did therefore not know about the number or type of staff I would have the opportunity to interview. Once there, the selection of interviewees was however strategic. I asked basically all personnel who have responsibilities in the organizations' health work and who were in a reasonable distance from where I was located, for an interview and all accepted. I interviewed three staff members and one (previously employed) volunteer at ISODEC using the tape recorder and one staff member via email. From CEDEP I interviewed three staff members, all with the tape recorder. The interviewees had coordinating or manager positions for the health work as well as regular staff positions within the organizations' health units. Among the interviewees were men and women in different ages. In addition to them, I interviewed two representatives from local NGOs, each one affiliated to one of the two organizations and co-implementers of the health projects. I did not use tape recorder with either of them and one of the interviews was done over the phone. During a field visit with CEDEP I also interviewed the Municipal Director of Health Service in Offinso and a community nurse in Dormaa Municipality. I conducted these two interviews with the hope to be able to paint the picture of intersectionality issues in the relevant regions. However, I realized that using a few short interviews to depict a credible picture of the situation is not possible. These interviews will therefore not be used in the analysis.

The location and time of the interviews are factors which can affect their character and outcome. I tried to arrange for the interviews to be held in private rooms and asked the interviewees themselves to pick a date so that it took place when the interviewees felt comfortable and had enough time. While I find

interviews to be a useful method when dealing with a concept as complex as intersectionality, it has its limitations and challenges. My position and standpoint as a researcher and interviewer is, as mentioned, related on my identity and personal background. The fact that I am a young white middle class woman, with an academic background in development studies and political science from a western country surely plays a role in my interpretation of the findings, but also in my relations with the interviewees. I recognize that the fact that I come from a western context to study a western concept in a non-western context can be problematic, both practically as well as politically in the sense that research processes are potentially reproducing power hierarchies (Ackerly and True, 2008 p.695). However, since my study focus is just as much the ideas which could be related to intersectionality as it is the organizations' potential usage of the theoretical concept, I find it to be feasible.

Both NGOs were academic work places preoccupied with development issues which are within my field of study. While the environment was familiar to me in many ways, the different culture in terms of hierarchy, working processes and interactions sometimes resulted in some insecurity from my side. The fact that I have a privileged and to some extent deviant background probably also shapes the staffs' and my perceptions of me and requires me to be aware of my behaviour and the position I might receive. Once there, I noticed that my role and tasks was somewhat unclear for the staff and some people kept calling me the intern. I recognized that I got easier access to the staff members with time and that their openness to me grew when they found out about characteristics or background of mine which were similar to theirs. Regardless of my position as privileged/non-privileged or outsider/insider researcher, the feminist proponents of situated knowledge claim that there are *no* innocent visions (Haraway, 2008 p.349). For instance, my different relationships with the interviewees surely influence the way I analyse their answers and interviews. The characteristics and identities of the interviewees obviously also affect the power relationships between us. All of these considerations are related to issues of intersectionality as such and requires me to be reflective. Throughout my study I had to be aware of intersectionality not only in the work conducted by the NGOs but in the relationships between myself and the organizations.

The interviews were not only a tool for finding out about the staff and the organizations' application of an intersectionality perspective, but an opportunity for me to ask questions arising from field visits, informal conversations or from reading reports and documents. The interviews, as well as my other material, were used to analyze how the organizations go about targeting, including and strengthening women within their health initiatives. The questions posed to the staff concerned the organizations' approaches, strategies, methods, projects' outline, content and participation. I also asked questions about women's health challenges in general and variations among women in terms of access to and acquirement of good health. I paid close attention to how women's inequalities and health challenges were discussed and presented by staff members. One of the central purposes of the interviews was to find out about the staff's perceptions of vulnerability and discrimination among groups of women in terms of acquiring

health and health care. Since I wanted to find out how the ideas of intersectionality were present among the staff members with or without them necessarily knowing of the concept of intersectionality, I used the word intersectionality quite sparsely in the interviews and managed to open up the conversation rather than steering it into an academic debate. Most of the times, the concept was briefly defined when presenting my study purpose right before starting the interview and it was also mentioned in a direct question about the interviewees' familiarity with it in the end of the interview.

## 4.6 Overcoming Interview Challenges

All of the interviewees had a positive attitude towards me, regardless of them meeting me for the first time or having spent a couple of weeks together with me. However, I recognized the risk of interviewees expressing strategies which in their opinion could or should be used to address issues of intersectionality instead of telling me about the actual situation and present strategies. This could have to do both with me asking unclear questions and with their willingness to answer appropriately. Because of this, answers related to the staff members' awareness were at times difficult to interpret. When realizing this risk, I tried to prevent the questions from encouraging these kinds of responses. Moreover, using reports and other documentation as complements mitigated this problem somewhat.

A related interview challenge was miscommunication. At times I found my exact research focus and purpose difficult to explain and was not sure that it was completely understood by the interviewees. Sometimes even after reformulating my interview questions, I perceived it as if we were still not on the same page. The problem, which partly seemed to be caused by contextual differences, was to some extent moderated by the fact that, as mentioned, most of the interviewees were academics who spoke good English. To further reduce this problem, I repeated some of the questions, to which I lacked answers, to other staff members. As mentioned, I also returned to some of the staff members at times, in person or via email, with clarifying questions. To overcome miscommunication caused by contextual discrepancies in concept definitions and meanings was tricky but essential when some of my study's most central concepts such as identity and discrimination were at stake. I therefore tried to be as specific and exemplifying as possible. Some identities were however more difficult to talk about than others. While sexuality is an important identity often mentioned in relation to intersectionality, I early on noticed the sensitivity of the issue and did therefore often not exemplify with it to avoid getting on the wrong foot with the interviewees. I basically only discussed the issue of homosexuality in one interview and in retrospect I regret not doing so more.

Challenges when conducting interviews also concerned time constraints, unfocused interviewees and the impossibility to be prepared when being thrown into spontaneous interviews on the field. As a researcher, I was also affected by the fact that some interviewees were somewhat distracted when presenting my



study. The lack of focus and busy character of some of the interviews sometimes made me simplify and cut down on the information about my study purpose and outline. I am aware of this, together with occasional misunderstandings, potentially being a problem in terms of achieving informed consent for the interviews. However, since all interviewees got some information and since the topic and interview questions were not particularly sensitive, I do not find it to be a significant problem. To further mitigate this problem, I have decided to keep the interviewees anonymous, using only their professional titles in the thesis, even though the interviewees did not insist on it.

## 4.7 Materials

Apart from the material provided by the interviews; documents, project reports, organizations' websites, field observations and academic literature have also been used in the study. To use a number of different sources and having them confirming certain notions and facts is part of a measure called triangulation. This measure strengthens the researcher's material and information base for analysis and enhances the validity of case studies (Yin, 2009 p. 41, 113-118). The variety of materials could also lower the risk of unconsciously studying the organizations' staff members alone instead of the organizations.

The documentation I acquired from the organizations in terms of reports, evaluations and project proposals was extensive, but not comprehensive. The reports I got access to were fairly often written by a network in which the national organization was part or in collaboration with a donating partner organizations. When searching for signs of an intersectionality perspective in CEDEP and ISODEC's work I therefore had to distinguish which positions belonged to them and which did not. The documentation I used came from current projects, but also from past ones when possible and relevant. Finding documentation where the NGOs' approaches, strategies and methods were systematically gathered and stated was difficult, but by piecing together information from interviews, project reports and websites I managed to get a fairly good picture of them. The fact that most of the documentation I got access to was not electronic and the fact that I did not manage to copy most of it could be problematic. However, while the documents are not possible to find on the internet, I accessed some of them via email. I (partly) copied the rest of them by hand. Furthermore, since most of the materials I used in my analysis from these documents correspond with what is mentioned by the staff in their interviews I think that it will not be a too big problem.

My field visits with CEDEP did unfortunately not result in a great amount of useful material, not least since they spoke the local language Twi during most of the activities. Yet, the activities did create questions about approaches and project designs which I brought to the interviews. During the field visits with CEDEP I also learned a lot just by having informal conversations with the staff and I find this information to be quite reliable even though it was not stated officially in an

interview. Most of this information was about the outline of project activities and I tried to confirm crucial aspects in interviews and documentations afterwards.

Except for the material gathered during my field study, I have used academic, journalistic and other literature to present my theoretical and methodological framework and the contextual background of women's health in Ghana. With regards to this material, I have tried to use reliable sources and often ensured crucial facts by comparing it to more than one source.

## 4.8 Analysis Strategy

In order to answer the research question I had to translate *applying an intersectionality perspective* into operational indicators and questions (Esaiasson et al, 2004 p.57). This was a huge challenge since there is no ready-made scale to determine or classify practices or strategies as influenced by an intersectionality perspective. Nevertheless, using my definition of an intersectionality perspective (2.3) as a starting point, I chose the following two overarching and operational questions to frame my analysis:

- In what way is there recognition of women's intersecting identities shaping their position in society and their health situation in particular? (*Found in staffs'/organizations' expressed views and knowledge as well as in organizational approaches, strategies and methods*)
- In what way is there recognition of women's intersecting identities shaping inequalities and discrimination among women in terms of health and access to health care? (*Found in staffs'/organizations' expressed views and knowledge as well as in organizational approaches, strategies and methods*)

With these questions guiding my analysis of the material I have structured the analytic section according to the following themes:

1. *Recognition of women's intersecting identities' impact on their health.* Central to an intersectionality perspective is, as mentioned, an awareness of women's intersecting identities shaping their societal positions and inequalities. In my search for ways of which ISODEC and CEDEP are applying an intersectionality perspective, it is therefore relevant to see if this recognition is found within the organizations' health work.

2. *Approaches, strategies and methods of CEDEP's and ISODEC's health work.* Since approaches, strategies and methods are central elements of the NGOs' health work, I have analyzed in what ways these have been informed by or can be related to an intersectionality perspective.

3. *Strategies of participation and inclusion.* Revealing and resisting exclusion and misrepresentation of certain women was central in the creation of intersectionality as a concept. This makes it relevant to seek organizational strategies for inclusive participation and consideration of women's intersecting identities when mobilizing to project activities. It also makes a case for analyzing the NGOs' strategic efforts to have inclusive outlines and contents of their health project activities.

4. *Familiarity with the concept of intersectionality.* While analyzing the awareness of the theoretical concept of intersectionality is not my primary aim, it is yet relevant to examine to what extent the concept is familiar to the NGOs. The theme also has the purpose of illuminating how the staff members themselves relate the concept to the work of their organizations.

The questions and themes are sprung from my theoretical understanding of intersectionality as well as from my cursory knowledge about the organizations' work. The interviews and documentation have been interpreted and analyzed in accordance with the overarching questions and structured in accordance with the themes. Since categorizations of answers as indicating an application of an intersectionality perspective or not could be quite arbitrary, my interpretation is crucial and have to be done in a credible way to achieve validity. In addition to operationalizing applications of an intersectionality perspective adequately, I had to be careful not to just analyze the recognition of inequalities among women, but their intersecting identities. Moreover, dealing with a theoretically complex concept as intersectionality made forming intelligible, relevant and precise questions about it challenging as well as interesting.

# 5 Analysis

In this section I analyze the work conducted by the two Ghanaian organizations in relation to an intersectionality perspective. The aim of the analysis is to shed light of ways in which the NGOs apply an intersectionality perspective in their work with women's health and thereby answer the research question. Since the organizations' health work primarily concerned women's sexual and reproductive health and rights, this is my analytic focus.

In order to answer the research question, I try to distinguish the work, responsibilities and strategies conducted by CEDEP and ISODEC and the affiliated NGOs on the local level. There are of course other actors, such as donors and local officials, who influence the course of the health initiatives and projects. However, to make the scope of this thesis manageable, these are not given much attention in the analysis. For the same reason, the analysis' focus is on local projects and to a limited extent on the organizations' lobbying and national and international advocacy for health issues. While most of the material concerns the two health projects I described in (3.2), others are also discussed in the analysis when relevant.

My definition of an intersectionality perspective, which was stated in (2.3), refers to intersecting identities. Yet, during my interviews I talked about identities as well as backgrounds interchangeably, since this increased the understanding between me and the interviewees. I therefore do so at times in the analysis as well. Finally, I have chosen not to have a separate analysis for each organization, since my focus was not to make a comparison between them but to get an insight into how Ghanaian NGOs apply intersectionality perspectives in their health work. My study showed great similarities between the two organizations regarding this, why a joint analysis seems appropriate.

## 5.1 Recognition of Women's Intersecting Identities' Impact on their Health

### 5.1.1 Diversity and Marginalization

While gender is described as the most marginalizing identity for women, CEDEP and ISODEC staff also identified other identities which intersect with gender and make certain women more vulnerable and powerless in terms of health than others.

Both organizations stressed the economic aspect of health issues and the problem of accessing adequate health care with little money. Women who do not earn their own money were also repeatedly described as too dependent on their husbands or other men for survival. According to both NGOs' staff, this leads to subordination of these women and their rights and bodies. These women can not make medical decisions or seek medical attention without approval of a man, which greatly compromises their health and rights. The identity as poor can also lead to rude treatment from health personnel. This was mentioned by several ISODEC staff members as well as by community members themselves in a report from a CEDEP community rally in Dormaa (CEDEP, 2012b).

Illiterate and uneducated women were another group suggested by ISODEC and CEDEP staff to be worst off in terms of reproductive health and rights. Illiteracy usually makes women unable to earn money and have a proper job and it also limits their knowledge about their health rights. The Coordinator of ISODEC's Northern Ghana Programme pointed to backgrounds and identities such as women's education, geographic location, ethnicity, urbanity/rurality and wealth as being influential for women's health experiences and challenges, not least regarding exclusion and marginalization. She however implied that noticing these variations was relatively new in the organization (2012-02-27).

The notion that not all women's voices are heard equally seemed to be well integrated among the staff. CEDEP's Education and Health Programme Manager, in charge of a HIV/Aids project, explained how local hierarchies affect women's health. Traditional societies often have a "queen mother" who is supposed to be the head of the women in a particular community. Women with education or wealth are also more likely to get leading positions among the women and are able to assert themselves. He argued that

the bottom line is economics, if you have economic fortune then you have a voice in the community, people will respect you, but if you don't have then you won't have the voice and you'll be living at the fringes of society (2012-02-06).

Another background or identity which many of the staff members of ISODEC and CEDEP returned to was culture. While culture was never clearly defined, it was repeated that certain cultures and cultural practices restrained women's health. Traditional and cultural practices were at times said to be causing women having to seek permission from their husbands to go to the hospital, something which directly affects their health. In reports and documentations from several ISODEC projects, it is described how culturally acceptable methods and approaches were used in the struggle for reproductive health (FRHP, 1999, ISODEC, 2011 p.2). To some extent, there also seemed to be an intent by the NGOs to challenge cultural behaviour, as in the Top project where community representatives

take charge of identifying, implicit and explicit cultural norms and practices that hinder effective health care access by women and children and report such factors to ISODEC and partners to devise and carry out appropriate advocacy for their elimination (Aboba, 2011).

Culture as a health determining indicator was mentioned by staff in a much greater extent than religion, which only few staff members mentioned. In some of the reports at hand, gender differences in vulnerability were furthermore depicted as being influenced by socioeconomic and cultural factors which has to be taken into account when conducting health initiatives (FRHP, 2000b).

While both poverty and cultural norms were claimed to be restraining some women from deciding over their own health and health seeking behavior, several staff members emphasized the vulnerability of women in need of permission to seek medical care without connecting it to any particular identity or socioeconomic circumstances. It was however evident that this problem primarily concerned married women and that these women's lack of decision-making power also made them especially difficult to reach with health initiatives. CEDEP's Health Manager argued that married women were often restrained from participating in reproductive health projects since their husbands saw family planning as a way for their wives to have sexual relationships with other men (2012-01-20). Another reason why husbands forbid their wives from participating without them was that they assumed that the wives were taught to reject their husbands from sex (ISODEC Volunteer, 2012-02-24). According to ISODEC's volunteer, unmarried women were because of this more likely to be free to participate in the organization's activities.

Rural women were another group often mentioned by the NGOs as explicitly vulnerable and difficult to reach with health initiatives because of economic, time and infrastructure constraints. Distance to health centres and inadequacy of health facilities were said to put rural women in the worst health position in the country (ISODEC Policy Analyst, 2012-02-22, Coordinator of Social Services Campaigns, 2012-02-17). I was also informed that rural women often lack information and independence in their health seeking behaviour and that many also experience coercion and pressure, not least by other women, to not seek professional care (ISODEC Coordinator for Northern Ghana Programme, 2012-02-27). They are furthermore more likely to be treated rudely by health personnel because of prejudices, lack of social understanding and common social codes between the health workers and the rural woman. The Coordinator said: "The nurse too do not understand the social setting of where she's coming from [...], so this is much about identity conflict" (Ibid).

Young women were rarely explicitly mentioned as being more vulnerable in terms of health, although youth were often one of the target groups for both organizations' health projects. Moreover, while women's reproductive health and rights were discussed frequently during the interviews, their sexual health and rights were not mentioned as often. As a result, women's sexuality was practically never presented as a factor or identity affecting women's position or health. This, among other things, gave me the impression of unwillingness to talk about issues of sexual orientation and certain identities.

As suggested above, when asking about women's inequalities in terms of health I found many indications of recognition of intersectionality issues. Some of

the material also expressed ideas of addressing and mitigating these inequalities and this powerlessness for women created by intersecting identities.

### 5.1.2 Discrimination

Asking about discrimination and exclusion in the interviews resulted in a variety of answers. While some staff members, after giving it some thought, could distinguish specific groups of women which tend to be discriminated in terms of accessing or taking part in health initiatives, others maintained that discrimination was practically absent.

Several staff members from both organizations described certain groups of women as subjected to discrimination or at least disrespect when interacting with health services. Both wealth and class were factors and identities said to influence the treatment a woman gets (ISODEC Coordinator of Social Services Campaign, 2012-02-17, ISODEC Coordinator for the Northern Ghana Programme, 2012-02-27). The Assistant Programme Officer at CEDEP said that while he cannot say that any discrimination has been shown in their projects or project areas, CEDEP knows that discriminations of poor people do occur during hospital visits. He also mentioned those without knowledge of their rights as vulnerable to discrimination (2012-02-02).

Some groups of women did not appear in discussions about what identities and backgrounds affect a woman's health and which women have greatest health challenges, but did so when discussing stigmatization and discrimination. Women living with HIV/Aids and with sexual orientations other than the heterosexual one were described as extreme outcasts. ISODEC's Coordinator for the Northern Ghana Programme explained that stigmatization of people living with HIV/Aids is immense and that these people might not open up or even come out of the house even though there is available treatment. Because of this, their health is compromised (2012-02-27). Yet, there were varied opinions about whether these stigmas created obstacles for these people to engage in health projects by the NGOs. While one staff member said this was the case, another claimed that the exclusion or discrimination is limited since "people living with HIV/Aids, they have their grouping and so ISODEC particular targets those groups" (ISODEC Volunteer, 2012-02-24). He also confirmed the stigma for people living with HIV/Aids and said that while health personnel in most cases do not discriminate, they will probably treat an HIV/Aids positive person bad or at least different, since she or he is seen as contagious (Ibid). The stigmatization based on sexual orientation was described as even worse, although in less details (ISODEC Coordinator for the Northern Ghana Programme (2012-02-27). A third group of stigmatized women were teenagers having abortions. ISODEC's Coordinator of Social Services Campaigns claimed that pregnant teenagers are seen as naughty girls by the health attendants, which at times creates problems and abuse of them when visiting health staff at the hospitals. He said that "at times they discourage some of them from seeking proper care, especially those who want to abort" (2012-02-17). Because of the health personnel's attitudes, pregnant teenagers

often undertake alternative treatments which “usually end painfully” (Ibid). The bad behaviour towards these young women is, according to him, also present within their own households and communities.

Despite ethnically and religiously diverse regions and districts, ethnic or religious minorities or identities were never said to be a source of discrimination in the areas of the organizations’ health projects. Nor were there, according to CEDEP and ISODEC staff any tensions between ethnic or religious groups which might affect the women’s health. Since I did not ask the CEDEP staff about discrimination connected to stigmatization I can unfortunately not present their views on it. However, some of their written material, such as a training manual for peer educators, community advocates and community leaders within CEDEP’s HAAP, devoted quite some space for issues of non-discrimination related to various identities and respect for difference. The manual also calls for action to be taken against discrimination (ARHR, 2008 p.22-24). However, this written acknowledgement of discrimination is difficult to define as an application of an intersectionality perspective. Moreover, while the Alliance for Reproductive Health Rights (ARHR) emphasizes promotion of non-discrimination within the project communities (Ibid p.29), one of the CEDEP staff did not find that discrimination against certain women in relation to health existed at all within the project communities (CEDEP Education and Health Programme Manager, 2012-02-06).

In a similar manner as with women’s intersecting identities leading to differences in health marginalization, there seems to be an intersectional recognition of discrimination among the staff, and in this case within ISODEC in particular. The fact that some staff members had a hard time distinguishing discriminated groups of women however makes me less convinced about their recognition of intersectionality.

### 5.1.3 Categorization

I early on noted that the commonly used theoretical categories of intersectionality such as ethnicity, religion, age, class and sexuality were seldom used by the NGO staff in their descriptions of the intersectionality context. Alternative categories of identities of marginalized and discriminated women were repeatedly mentioned and especially so during the interviews. Married women, women from certain cultures (vaguely defined), rural women and women living with HIV/Aids are examples of categories of women facing greater health problems and being more difficult to reach with health initiatives than others. I find this difference between the theoretic and empiric categorization interesting, not least since it could raise the question of the usefulness and relevance of intersectionality perspectives as analytic tools. However, this issue has been illuminated by some proponents of intersectionality. Lykke writes that

[...] it is important to create a thematic focus (*in casu*: gender/sex in their intersections with other power differentials and identity markers), but it is just as important to do so



without fixing the production of knowledge with delimiting and hence excluding and essentialising definitions (Lykke, 2010 p.45).

Categorization is, as mentioned, a central issue in feminist theory as such and the debates around its possibilities and limitations are many. Numerous of feminist scholars emphasize the risk of essentialization and universalization of categories, not least in relation to theoretical standpoints of intersectionality (Wong, 1999). In addition to her call for caution regarding “fixing the production of knowledge”, Lykke also suggests that since intersectionality as a concept has to do with societal inclusion/exclusion and dominance/subordination, it can therefore in principle include new categories than the traditional ones (Lykke, 2010 p.54-55). I align myself with this notion and believe, as a result of my findings, that all intersectionality studies have to be well rooted in the empirics of local settings.

The fact that most of the theoretical categories of intersectionality were not mentioned during the interviews strengthens the notion that categories have to be understood in the light of and as products of societal political, economic and social processes (Ibid p.45). Thus, it is not only the theoretical element of intersectionality which could make it difficult to apply in particular contexts, but the fact that it is sprung from a western context and refers to categories of identity which are relevant for those power struggles and relationships that are prominent there. However, this does not necessarily mean that the theory in itself is not applicable to other contexts than the western one. It means that intersectionality perspectives’ universal usefulness, according to me, relies on the possibility to include alternative categories.

Besides deriving from the political and socioeconomic context in which intersectionality was formed, I perceived it as if some of the categories or identities were rarely touched upon by the NGOs, not because of their unfamiliarity but because of their sensitivity. One clear example was sexual orientation. Homosexual women are for instance, as mentioned, a highly stigmatized group which the staff avoided or did not find relevant to talk about. Going through the material of CEDEP and ISODEC, I also found that the categories of the most marginalized and excluded women in terms of health were quite often not connected to identities but rather to practicalities and physical constraints of certain groups of women. The fact that rural women were repeatedly mentioned as difficult to reach and explicitly vulnerable in terms of health, exemplifies that the categorization has to do both with the group’s practical, economic and political circumstances and with intersecting identities weakening their power position. The circumstances affecting rural women’s health were for example their distance to health facilities, inadequate infrastructure and lack of money, time and information (ISODEC Coordinator for the Northern Ghana Programme, 2012-02-27, ISODEC Policy Analyst, 2012-02-22). The identity-based reasons to their vulnerability were coercion in health seeking behavior, lack of independence and bad treatment by health workers. Moreover, while intersectionality largely emphasizes identity, power positions and inclusion/exclusion, the practitioners I talked to about health did not identify problems or categorize people accordingly. Project reports from the HAAP where

community members' own words about their health are depicted also shows that discrimination or women's identities are almost never presented as a problem for achieving good health, with the exception of poor women (CEDEP, 2011a, CEDEP, 2011b). Here as well as in the reports and documentations from the ARHR's projects, where ISODEC is one of the main implementers, the issues brought forward are often of more practical and physical character. Development issues such as income generation, credit and literacy are said to be addressed within the Family Reproductive Health Programme because of their interrelation with access to health, while writings about identity issues are absent (FRHP, 1999). I believe that the reasons for this can be many, and one might be that practical hinders to health, which of course are highly relevant, are easier to talk about, less diffuse and more hands on than identities and power hierarchies. It is of course not always easy to separate identities from circumstances. The circumstances might be a result of a group's weak power position and circumstances might also lead to a certain group's marginalization. Nevertheless, CEDEP's and ISODEC's discussions regarding women's different health challenges and marginalization indicate that there is recognition of women's intersecting identities affecting their position, health status and to some extent discrimination, within the two NGOs. The fact that practicalities rather than identities and power positions so often are mentioned however makes an intersectionality perspective within the organizations less obvious.

## 5.2 Approaches, Strategies and Methods of CEDEP's and ISODEC's Health Work

### 5.2.1 Approaches

It is clear that the two NGOs are influenced by international development and gender discourses and concepts. Participatory approaches, rights-based approaches and gender mainstreaming were the three most prominent approaches I found and they are all widespread within the development sphere and among academics. Intersectionality is however not among the NGOs' stated approaches, which, as I touched upon earlier, is not too surprising since it to a large extent has been presented as an analytic tool rather than an organizational approach. Yet, by asking the staff about the meaning and usage of these three main approaches, I wished to see if they could be connected to intersectionality in any way or perhaps even overlap the intersectionality perspective.

ISODEC and CEDEP's approaches for their health work were fairly similar and to a large extent consistent with their work in other areas. Staff members of both organizations repeatedly emphasized participatory approaches and methods which had great focus on community involvement and local ownership. The

Health Manager at CEDEP described participatory methods, in general terms, as methods where community members are involved in the process of training and conceptualization to avoid changes being imposed on them. CEDEP's principles of participation imply that "the advocacy issues come out of community meetings where they themselves identify issues and prioritize them" (CEDEP Health Manager, 2012-01-20). Participatory methodologies are also used by the organization in order to "interact with the people to solicit their opinions about an issue in order to get in-depth knowledge about a situation" (CEDEP Education and Health Programme Manager, 2012-02-06). Participatory methodologies are furthermore emphasized in one of CEDEP's project reports (CEDEP, 2011a) and by the representative of the local NGO co-implementing the HAAP. Community participation is also presented as an essence in the work of ISODEC, although my discussions with the staff members on the issue and the meaning of it were fewer there than with CEDEP. Participatory methods are also mentioned in ISODEC's project reports (ISODEC, 2011 p.2-3).

The second set of approaches which was urged by ISODEC in particular were rights-based approaches. The approaches, which have been buzzwords in the development sphere during the last couple of decades, seem to be well rooted in the NGO. According to the ISODEC's Coordinator of Social Services Campaigns, the rights-based approaches are about

appealing to constitutional [...] guarantee of certain rights which have been documented and could be referenced and using that as a source of our advocacy and then also internationally appealing or referencing some international agreements bordering on human rights (2012-02-17).

In addition, the ISODEC volunteer claims that rights-based approaches are about educating people about their reproductive rights and how to demand them (2012-02-24). Rights-based approaches were also stated as being central in certain project documents by the ARHR, in which both CEDEP and ISODEC are involved (ARHR, 2006).

The third approach which I find to be prominent in the organizations' health work has to do with gender mainstreaming. Carrying out gender sensitive work throughout, or mainstreaming gender as they referred it to, was emphasized by CEDEP and ISODEC staff as well as in some project documents by ISODEC and in CEDEP's mission statement (CEDEP, 2012a). The Coordinator of ISODEC's Northern Programme described an ambition and conscious effort of gender awareness throughout the organization, from the management level to the programme level (2012-02-27). A report on the FRHP however indicates that more needs to be done to integrate gender into the programme and to go beyond just targeting women (FRHP, 2000b p.4). A precise meaning of gender mainstreaming and sensitivity has furthermore been difficult to deduce from any of the two organizations.

I found that none of the approaches brought forward by the organizations are easily related to an intersectionality perspective. Studying CEDEP's staff's way of speaking about participation and how it is portrayed in the reports, it seems as if

participation has to do with community involvement in project processes as such (CEDEP, 2011a p.4-5) rather than being concerned about which people are and are not making their voices heard in the community. Yet, the emphasis on local ownership was partly in order to increase the knowledge about the local setting and the people living there (CEDEP Education and Health Programme Manager, 2012-02-06). One might say that this local knowledge *could* strengthen the possibility for CEDEP to create an inclusive participation and adjust the health initiative to fit women with different intersecting identities living in the communities. This notion is however difficult for me to confirm. I will nevertheless later, in (5.3), analyze more specific strategies and methods for representation and inclusion brought forward by both organizations and see how they can be related to intersectionality. The rights-based approaches used by the NGOs are compatible with ideas of intersectionality by emphasizing rights for all and challenging discrimination, but can with this empirical material not be said to be interlinked. Gender awareness of some kind can be said to be a precondition for intersectionality perspectives in the sense that gender is, from an intersectionality point of view, one but not the only identity affecting women's position. It does however not equal an intersectionality perspective and, as mentioned initially, a too great focus on gender inequalities risks blindfold other sorts of inequalities. Additionally, I have not set myself out to analyze the organizations' success or the exact way of implementing their approaches and strategies, why it is even more difficult for me to give a clear answer about the links between them and an intersectionality perspective.

### 5.2.2 Strategies and Methods

The multitude of strategies and methods for CEDEP's and ISODEC's health work are not possible to fit in this section. I will therefore try to limit the depiction to the most prominent ones.

Awareness rising and information about sexual and reproductive health and rights is a pervading strategy in the NGOs' health projects. The awareness rising was conducted using various means. Radio shows and door-to-door information campaigns were examples of methods used within ISODEC's Top project. As described in (3.2), a knowledge exchange between traditional birth attendants (TBAs) and professional health workers was also arranged so that the professionals learned about traditional treatments which will make rural women less reluctant to seek professional help (Oxfam, 2011 p.3, 12). Another strategy or method commonly used by both CEDEP and ISODEC was awareness rising through peer educators. These young women and men were educated on issues of reproductive health by the national NGOs and thereafter educated their peers (CEDEP Education and Health Programme Manager, 2012-02-06, ISODEC Volunteer, 2012-02-24, ARHR, 2009). CEDEP's Education and Health Programme Manager exemplified:

Then we have one-on-one interaction, that's the peers they have been trained in such a way that they can reach out to individuals with the message on HIV/Aids or to train the people they meet to live a safer sex life (2012-02-06).

The spread of information is, according to ISODEC's Coordinator for the Northern Ghana Programmes, crucial since information is something which all women, regardless of identity and background need (2012-02-27). The fact that a variety of channels are used to distribute information and raise awareness with the aim of reaching as many women as possible with knowledge, is to some extent a recognition of women's diversity. It is however not possible for me to characterize the awareness rising in itself as part of an intersectionality perspective.

Advocacy is a common strategy of the two NGOs. CEDEP's HAAP had the explicit aim of training and building capacity among community members to advocate for their health rights and provision of adequate sexual and reproductive health services (CEDEP Assistant Programme Officer, 2012-02-02, ARHR, 2009). During the HAAP, CEDEP often gathered community members and representatives from Ghana Health Service and the local Assembly to discuss and advocate for the community members' causes. ISODEC also supports community advocacy, and at the same time carry out national advocacy through established partnerships and networks with institutions, organizations and actors within the field of health (Oxfam, 2011 p.10, ISODEC Coordinator of Social Services Campaigns, 2012-02-17, FRHP, 1999). ISODEC's Policy Analyst explained the process of advocacy and said that once the message has been established, the question to ask is how to channel it to the community members (2012-02-22). The NGOs' emphasis on advocacy for rights rather than service delivery could be seen as favouring an intersectional point of view, since health rights for all would challenge power hierarchies among women as well as benefit women with all kinds of intersecting identities. I would however not call it an intersectionality strategy as such.

Another strategy repeatedly mentioned by staff from both organizations is the inclusion of men in the health initiatives (Ibid, CEDEP Education and Health Programme Manager, 2012-02-06). ISODEC's volunteer described the involvement and awareness rising of men and particularly husbands as crucial in order for them to let their wives take part in health projects and make use of family planning. CEDEP's Health Manager even argued that "if you empower the woman and the man does not understand, you'll not achieve anything" (2012-01-20). By speaking to the staff I also got the feeling that this inclusion is about sensitizing men about women's health rights and also making them feel like they are part of the health initiative instead of being anxious about its content. This strategy seems to be designed to address the issues of married women in particular, even if sensitization of men of course benefits society at large. Since married women were recognized as a group with great health challenges due to lack of independence, the strategy can be seen as addressing an intersectionality issue.

The NGOs' overall emphasis on participation of community members with local knowledge is demonstrated in projects such as the Top project. Community health committees were strategically formed to discuss and address pressing issues of maternal health. The members of the committee have a great share of the responsibility of both practical, informative and advocacy tasks (Oxfam, 2011). During informal conversations as well as a sporadic interview, the staff mentioned that local representatives, advocates and peer educators are crucial instruments in reaching communities since they are the ones who live among, have knowledge about and can connect with the people in the communities (CEDEP Education and Health Programme Manager, 2012-02-06). As mentioned before, one might say that this is favourable in terms of knowledge of women's intersecting identities and diverse health situation, but it can not be seen as a guarantee for it or a conscious strategy of intersectionality.

Since intersectionality is often used as an analytic tool to detect inequalities based on identities, I was interested in knowing if ideas of intersectionality could be found in the NGOs' analytical work. By analytical work, I basically mean the planning and preparation phase of the health projects. Unfortunately, I did not get so much out of the interviews on this matter and the documentation mostly evolved around project activities. Some staff members however emphasized the importance of conducting some kind of pre-project analysis before initiating the project to learn about the issues and thereby which people to target. I also found one documented pre-project analysis of health project by ISODEC. The aim of this analysis was to determine access to, and utilization of health services among the poor and underserved and to explain how gender identities and power relations in communities influence health and reproductive rights and outcomes (ARHR, 2007 p.1-2). When conducting the analysis, community members were asked questions about: How and if different groups (cultural, geographical and social) of people access information and services of sexual and reproductive health, the different information needs among different groups, which services and providers different groups feel most comfortable using, what is influencing health-seeking behaviour and decision-making regarding use of services and providers, what the key barriers to access are identified by different groups within the community etc (Ibid p.9-16). I think that the questions asked in this ARHR pre-project analysis indicate recognition of the variations between groups of women or people in terms of health needs, experiences and opportunities. Even though the different groups are not defined by intersecting or multiple identities, I consider this practice to show an awareness of the fact that social categories and identities shape people's health situations and positions. I would however not refer to this as an intersectionality analysis.

### 5.3 Strategies of Participation and Inclusion

### 5.3.1 Participation

Exclusion is an important theme in intersectionality research, why I find it important to study the ways in which the two NGOs work for participation and inclusion. My focus lies particularly in seeking strategies with the purpose of having an inclusive participation and which considers several dimensions of women's social inequality when inviting and mobilizing to project activities. These strategies are not to be confused with the organizations' participatory approaches which I've already touched upon.

The presence of official strategies is difficult to assure through the interviews and documentation, but I did come across many notions of more or less planned strategies of inclusion and participation. The sexual and reproductive health projects conducted by both organizations frequently targeted women of reproductive age and youth, but I was told by CEDEP and ISODEC staff and affiliated representatives that *all* women, within the targeted groups and areas, are invited to the projects and that broad participation is emphasized. The project activities were described by staff and in the written material as open forums where everyone was welcome to join (Oxfam, 2011 p.10, CEDEP Education and Health Programme Manager, 2012-02-06). While my field observations suggested quite a spread of participants in terms of sex, age and ethnicity (based on the look of their clothes), other identity markers were difficult for me to detect. Draft reports from the HAAP meetings however showed that the participation from people with different professions and social associations and affiliations was quite broad (CEDEP, 2012b p.2-3, CEDEP, 2011a p.4-6, CEDEP, 2011b).

To map out strategies by CEDEP and ISODEC for inviting and mobilizing female community members to participate in project activities is difficult since most of the actual invitation processes are done by the affiliated local NGOs. However, in several projects, the CEDEP and ISODEC have criteria for the participants which serve to guide the local NGOs in their invitation process. According to CEDEP's Assistant Programme Officer, the organization's criteria for the selection of participants to the HAAP were that there should be a good representation of "both sexes, age groups and all that" (2012-02-02). I was also told that CEDEP tries to make sure that people from the major groups are represented in terms of religion and profession etc. Since CEDEP finds the variety of participants to be important, they advice that people are invited through different associations and groups (e.g. church groups, religious gatherings, youth groups, and profession associations etc) (CEDEP Assistant Programme Officer, 2012-02-02). As in the case of CEDEP, ISODEC is responsible for the formal invitation, while the local NGOs are responsible for the physical invitation and mobilization of people to their Top project. In terms of participation in the community health committees, the project proposal suggested that the representation should be broad in terms of "ethnic, social, economic and political groups within the village communities, with a strong bias for the most vulnerable populations" (Oxfam, 2011 p.10). However, an interview email from ISODEC's former Top project Coordinator and project reports suggests that the selection of committee members is based on personal character and eligibility rather than on

diversity of backgrounds (2012-05-07, ISODEC, 2011 p.3). Moreover, while CEDEP's criteria might create broader participation than what would be the case without them, they did not seem to cover all women within the target groups. For example, people with disabilities (PWDs) were one of the target groups of the HAAP, but were not mentioned in CEDEP's criteria. CEDEP's Assistant Programme Officer furthermore said he "cannot recollect if we have had anyone representing PWDs in any meeting yet" (2012-02-02). This indicates that while the organizations to some extent think strategically about how to create an inclusive participation, they do not always encompass everyone and the implementation can be uneven. Hence, I found it difficult to determine if the NGOs' strategies to create an inclusive participation through selection criteria should be seen as a way of addressing intersectionality issues of some women's exclusion per se or a general ambition to include as many community members as possible.

According to ISODEC staff, among the major hinders for women's participation in public project activities were practicalities, gender imbalances and cultural backgrounds. ISODEC's Top project therefore had several elements which served to create a broad participation and reach out to as many women as possible in its activities. One of ISODEC's ways to overcome these problems was to carry out the so called door-to-door awareness raising activity. Within the targeted communities, all homes were visited by trained community members to inform and talk about issues of reproductive health and rights which were relevant for the household in question. By doing so, women, who for different reason would not be able to come to the project activities, were still provided with some information (Representative from Integrated Development and Health Centre, 2012-03-13, Oxfam, 2011 p. 11). By recognizing differences among women and inequalities based on other factors and identities than gender, this method serves to make sure that all women get the information they are entitled to.

A strategy used by CEDEP in particular to enhance participation from younger people was to recruit women (and men) through peer educators, who made the projects seem attractive (CEDEP Education and Health Programme Manager, 2012-02-06). Packaging the project in order to make women participate was also mentioned by CEDEP's Assistant Programme Officer when discussing participation from different kinds of women. He said that the organization makes sure that they know about the community members' backgrounds so they can present the project for them in the best way. This is not least important when it comes to addressing culture and religion as hinders for women's participation in the health initiatives (2012-02-02). However, since these methods are quite diffuse and not clearly related to certain women's exclusion, I cannot say if they indicate an intersectionality recognition and perspective.

While many staff members suggested that stigmatization of people living with HIV/Aids makes them unlikely to attend project meetings, I found few strategies within the organizations for reaching stigmatized groups. However, as mentioned before, people living with HIV/Aids in the FRHP communities usually form groups which ISODEC targets in particular with the project message and thereby mitigates their exclusion and discrimination (2012-02-24). Some proposals of



strategies to reach stigmatized women were also brought forward by ISODEC's Policy Analyst, who was new in his job and not quite sure whether the organization had a specific strategy for making them participate or not (2012-02-22). By talking to ISODEC's Coordinator for the Northern Ghana Program about participation of stigmatized groups, I got the impression that homosexuality was a too sensitive issue within and outside of the organization to be addressed in terms of participation and inclusion. The Coordinator referred to the topic as "hot and controversial" but does personally, however, not believe that there were many people having other sexual orientations than the heterosexual one in the rural areas where ISODEC's projects are mostly located, why exclusion would not be a problem (2012-02-27).

While the organizations do have some strategies for creating a broad participation of women, they seem to be quite fragmented and at times vague. Furthermore, whereas I find that some of the strategies are informed by an intersectionality perspective, others are more questionable. At times, the NGOs' recognition of intersectionality also appeared to be difficult to apply in practice, such as in participatory strategies. Staff members from both NGOs described some of the contexts in which they operate as being so extremely oppressive of women that inclusion of *any* woman in committees and assemblies was a huge challenge in itself. In those cases, participation of all women and particular attention given to women facing enhanced discrimination might not be a realistic short term goal. Finally and noteworthy, I do not mean that only women who participate in the activities can benefit from the health initiatives or get a better power position from them. However, I find that that misrepresentation of certain groups of women and their experiences and voices, as discussed by Crenshaw (1991), is more likely to occur in project activities, such as health rights advocacy gatherings, if they do not participate.

### 5.3.2 Inclusion

To analyze the organizations' strategies of inclusion, in present study, means examining how the outline and content of the health initiatives are adapted to address the diversity of intersecting identities among women. One of my central questions of interest was which methods the NGOs use to create inclusion and involvement (rather than sole participation) of women with different identities in the projects, with their specific target groups in mind. While Crenshaw's idea of challenging misrepresentation of colored women was connected to the political sphere (Lykke, 2010 p.71), I find that it is relevant to see if the NGOs have any strategies for making sure that all kinds of women get their voices heard and acknowledged.

On the basis of intersectionality, I believe that women's intersecting identities makes it necessary to analyze ways of approaching different women in health projects and not assuming that the same approach is applicable for all women. Apart from the processes of invitation, selection and participation of community members, presented in (5.3.1), I was therefore interested in knowing about how

the meetings were organized to make it comfortable and possible for a wide range of women to take part. The general answer I got from both organizations was that different methods are used depending on the activities, situations and which categories of people to reach (CEDEP Assistant Programme Officer, 2012-02-02), ISODEC Policy Analyst, 2012-02-22). CEDEP's Assistant Programme Officer expressed that CEDEP at times used role play and expressive practices within the HAAP to adapt the content to the youth in particular (2012-02-02). The Education and Health Programme Manager responsible for CEDEP's HIV/Aids project similarly expressed the need for the organization to use more youthful means to reach young men and women. He mentions channels such as radio and the internet, but also emphasizes the peer educators' crucial role because of their ability to easily connect with this group (2012-02-06). Having segregated focus group discussions where men, women and youth at times are separated was another strategy used by CEDEP. It serves, among other things, the purpose of making women feel freer and more comfortable in speaking about reproductive issues which increases the organizations knowledge about specific young women's situation. To me, this implies an effort to address some of women's intersectionality issues.

ISODEC's projects and activities were also said to be adapted to fit the participants' backgrounds and identities (ISODEC Former Top project Coordinator, 2012-05-07). Segregated group discussions were held by ISODEC as well and ISODEC's Policy Analyst described how people were separated depending on the topic of the meeting to enhance engagement (2012-02-22). Within the Top project, meetings which addressed issues of motherhood only invited mothers or women in reproductive age (Representative from Integrated Development and Health Centre, 2012-03-13). ISODEC's Policy Analyst underlined the importance of adapting to the local hierarchies when implementing projects and describes how, in some projects, men and women from different age groups are separated, to avoid the young community members being overthrown by the ascendancy of older ones (2012-02-22). I believe that the variety of methods and activities within the Top project is an indication of a conscious attempt to address the variety of intersecting identities within the targeted groups of women and work for inclusion. Apart from the already mentioned door-to-door awareness rising, whereby women in all community households are reached by tailored information about reproductive health, activities such as drama performances and radio programmes are other examples of this attempt. The radio programmes have the aim to

attract men, women and children from all different age groups, backgrounds and interests to engage with issues concerning maternal healthcare and raise greater awareness about health rights and entitlements (Oxfam, 2011 p.11).

A representative from the local NGO, Integrated Development and Health Centre, explained that different actors take turns in making the radio programmes. It could be his local NGO, the community people or Ghana Health Service. The radio programmes reaches everyone with a radio in the region and since they are broad

in terms of topic it allows different kinds of people to pick up what is relevant for them. According to him, in that way it reaches people with different backgrounds and identities (2012-03-13). While the diversity of strategies or methods is favourable in order to reach a broad range of women with information about sexual and reproductive health and rights, it is difficult to refer to them as being part of an intersectionality perspective or to define them as bringing forward voices of women with different intersecting identities.

Despite good intentions, achieving active involvement from all community members is not easy, not least because of the stigma certain groups of women face. ISODEC's Policy Analyst claimed that even if everyone participates it does not mean that everyone's voices are necessarily heard or that everyone benefit from it. Wealthier women, leader women or older women are most likely to claim their space and be heard. In the same vein he noted that all "those who are not given birth, randomly discriminated are left out" (2012-02-22). For this reason, CEDEP's Education and Health Programme Manager emphasized the importance of a good facilitator in order to adapt the meetings to fit different women and to create participation from all kinds of women at meetings (2012-02-06). Besides separating and making groups smaller to bring forward the voiceless in discussions, the facilitator should also be able to break the ice for those women who are stigmatized and let people know that it is important for them to be heard (Ibid). This idea can be related to an understanding of intersectional exclusion and inclusion, but I found it unclear if it was an actual practice or only an ambition or suggestion.

As in the case of strategies for participation, overcoming socio-cultural barriers is by staff members seen as central in order to create inclusive health projects. Cultural sensitivity, culturally accepted methods and language and culture-adapted information was emphasized by both NGOs, although once again somewhat vaguely (ARHR, 2008 p.29-30, FRHP, 1999, ISODEC, 2011 p.2). Yet, their concerns about culture as a hinder for participation seemed to be mostly focused on the prevailing culture in the local community rather than on culture as an intersecting identity which creates social inequalities between the community women. Furthermore, their meaning of the concept of culture was never really established, why I will not address it further in this paper.

Language and religion barriers for inclusion were among the topics I discussed with CEDEP's Assistant Programme Officer after my field observations within the HAAP. The two meetings I attended were opened and closed with a prayer and I was told that it was not uncommon that the venue for the HAAP meetings was a church. When asking about the possibility that it might make some people feel uncomfortable and avoid coming, he responded that although that is possible, the meetings held in any religious institution is normally a consensus of the people. He also said:

My personal observation is that once a programme is organised for a community, the people participate in spite of the venue. However, when the participants are asked to pray it is open to every religion prayer. For instance there are many occasion where we have had a Christian saying an open prayer and a Muslim saying the closing prayer. CEDEP

has actually encourage that during meetings where if one religion prays at the start another is requested to say the closing prayer (2012-03-05).

In line with this effort to be religiously inclusive, the educational films which were shown at the two HAAP meetings I attended included both Christian and Muslim contexts and people struggling with issues of reproductive health. In terms of language barriers, I learned that Twi, a language mostly spoken in the Ashanti region where Kumasi and the HAAP districts are located, and to some extent also English were used at the project meetings and activities. According to the Assistant Programme Officer, these two languages were understood by most people. Because of this, he assured that exclusion in terms of language was generally not a problem (2012-02-02). These examples reinforce my notion that the outline of meetings and other activities to some extent seemed to be consciously adapted to the recognition of women's intersecting identities. However, these recognitions may not always be possible to translate into an intersectionality perspective per se.

While the organizations do not refer to stated strategies of inclusion, they are, according to me, to some extent observant of the variations of people involved and use different methods to fit women with different intersecting identities. Yet, one might however ask the question of which women are left out when the NGOs' design their project activities to fit women with intersecting identities. Clearly it is practically difficult to address all sorts of power hierarchies and social inequalities among women. At the same time, questions of this sort are central in intersectionality research. In a well cited paper, Maria Matsuba depicts how exclusion or subordination can be understood by asking "the other question".

When I see something that looks racist, I ask, 'Where is the patriarchy in this?' When I see something that looks sexist, I ask, 'Where is the heterosexism in this?' When I see something that looks homophobic, I ask, 'Where are the class interests in this?' (Matsuda, 1991 p.1189).

Finally, it is difficult to determine to what extent the strategies of inclusion *challenge* the power structures and inequalities caused by intersectionality issues among women. However, if an intersectionality perspective is to be applied and if the power structures related to women's intersecting identities are to be addressed, taking practical measure and adapting project designs as have been done by the NGOs is, according to me, needed.

## 5.4 Familiarity with the Concept of Intersectionality

When asking CEDEP and ISODEC staff about their familiarity with the concept of intersectionality, I most often got the answer that it was not something they had heard of before. As mentioned, I could not find any explicit mentioning of

intersectionality as concept, perspective or approach in the written material at my disposal either. However, after describing the perspective, several staff members from both organizations, could relate it to their work in one way or another. For instance, ISODEC's Coordinator of Social Services Campaigns said that most Ghanaian civil society organizations reject a gender agenda where for example urban women and their situation and aspirations alone set the norms. Such an agenda does not, according to him, solve the underlying problem or bring onboard the majority of women in the country. He concludes the discussion with the following notion:

So there's some consciousness around the issue but [...], I wouldn't say that I have come across any comprehensive approach at dealing effectively said that gender based policies that advocated for come out addressing the needs of these diverse groupings that you have, within even women folks (2012-02-22).

On the question of whether the NGO use an intersectionality perspective in their health work, CEDEP's Assistant Programme Officer responded:

I believe we use something similar to it, maybe the names might be different [...] whatever we do we know people have different roles they play at certain times and they have different aspects in their lives so we try to bring onboard all that in the projects that we design and even in the implementation of the project (2012-02-02).

These quotes indicates that the notion that women's intersecting identities and backgrounds are of importance and needs to be acknowledged does not come from knowledge of the theoretical concept of intersectionality, but rather from their experienced reality. Sometimes it seemed as if I was asking about obvious issues and that most interviewees thought it was obvious that women's various identities and backgrounds shapes their positions, experiences and inequality. As the analysis has shown so far, awareness regarding intersectionality can be present without knowledge about the theoretical framework of intersectionality. This relates to Lykke's term "implicit' feminist intersectional analysis", which refers to analyzes of social categorizations and their intersections without necessary using the theoretical term intersectionality (Lykke, 2010 p.75). Similarly, in the instances where the two NGOs seem to apply an intersectionality perspective, they do it in an implicit way.

As touched upon in (5.1.3), discussions of intersectionality with the NGOs' staff often slid into discussions of how other sectors or aspects are connected to ones' health rather than different identities and backgrounds. Referring to "interconnectivity", CEDEP's Health Manager for instance emphasized that health does not stands alone but is connected to infrastructure, banking, agriculture, number of children, woman's position in the family etc. She also spoke about interactions between sectors rather than identities although this was not how I defined intersectionality (2012-01-20). Once again this suggests that isolating women's position and experiences to their identities is uncommon in the context of these Ghanaian NGOs. Moreover, when speaking of health challenges

with the practitioners from the national and local NGOs, I got the sense that it is more relevant to speak about all things that affect women's health in the country instead of limiting the discussion to identities and backgrounds. It could however steer the spotlights away from identities causing differences in power positions and thereby, as argued in (5.1.3), make the applications of an intersectionality perspective less obvious within the organizations.

## 5.5 Analysis Summary

To distinguish elements of a complex theoretical concept as intersectionality in views and practices of these two organizations has not been easy. It was clear that gender was perceived by the staff members as one of the most important dimensions of social inequality (CEDEP Health Manager, 2012-01-20, ISODEC Coordinator for the Northern Ghana Programme, 2012-02-27). However, I argue that there is some recognition of women's diverse health positions and situations due to their intersecting identities. The staff's recognition of certain women being particularly marginalized in terms of health and difficult to reach with health initiatives does not alone mean that the organizations are applying an intersectionality perspective. It is however a precondition and an important ingredient. I have to some extent also spotted intentions of challenging local hierarchies and power inequalities related to intersectionality.

The analysis illuminates that CEDEP's and ISODEC's acknowledgement of the importance of women's intersecting identities and backgrounds does not come from knowledge of the theoretical concept of intersectionality, but rather from their experienced reality. While there are indications of intersectionality issues being recognized by the organizations, several of the categories of women mentioned by the NGOs are not among the traditional ones within intersectionality. In my opinion, this does not designate a lack of recognition of intersectionality, but rather that it is important to adhere to locally relevant categories. The acknowledgement of discrimination due to intersecting identities varied, but a majority of the staff members distinguished certain groups of women facing discrimination in terms of accessing health care or because of their health status. However, the fact that women's vulnerability often was related to practicalities rather than identities and power positions, somewhat lessened my impression of the relevance of an intersectionality perspective within the NGOs.

My analysis suggests that the overall approaches used in CEDEP and ISODEC's health work are not interlinked with an intersectionality perspective, although they do not contradict it. Among the strategies and methods of the organizations there are however those which either recognize particularities among women's health situations caused by their intersecting identities or at least are compatible with an intersectionality perspective. Yet, there are also those where no clear relation intersectionality can be found. Because of this, I find it quite difficult to make a cohesive statement about their approaches, strategies and methods.

While the organizations do have some strategies for achieving broad participation of women, overall they seem to be quite scattered and implemented unevenly. It was also to some extent difficult to distinguish strategies since the responsibility for the mobilization of participants mostly fell on the local NGOs and community representatives. Whereas I find that some of the strategies are informed by an intersectionality perspective, many of them are uncertain in this sense. I found a number of strategic attempts within the NGOs to create inclusive health projects, although some are difficult to establish as an application of an intersectionality perspective. My analysis also suggests that both organizations to some extent used different methods depending on which categories of people to reach and adapted their activities' outline and content to give voice to women with different intersecting identities. Their meetings' design quite often seems to be informed by some intersectionality recognition, although it occasionally was difficult to determine what their ambitions were and what their actual strategies were. The analysis also touched upon the fact that, while many intersecting identities and inequalities seem to be addressed, some are not. For instance, there seems to be quite few practical measures taken to address the health situation of stigmatized women such as homosexuals and to some extent women living with HIV/Aids or disabilities. Even though some material indicate that project participation was quite broad, stigmatized women seemed to be quite absent.

To sum up, the NGOs do not apply an intersectionality perspective in a formal sense, as an official policy, approach, strategy or analysis in their health work; Instead, I find there to be some indications of a perspective which take into consideration that gender has to be seen in the light of other social categorizations and that intersections of these social identities shape power relations and social inequalities (see definition of intersectionality perspective in (2.3)). I mean that an intersectionality perspective is primarily present in CEDEP and ISODEC's strategies of inclusion and in their recognition of women's diversity in facing health challenges and discrimination. I find it to be less apparent in the NGOs' approaches, strategies and methods and in their strategies for participation.

## 6 Concluding Discussion

The findings of this study indicate that while gender may be the most prominent lens through which these development NGOs see women's discrimination and vulnerability, it is not the only one. The degree of recognition of intersectionality issues and the presence of an intersectionality perspective does however seem to vary within different aspects of their work. The fact that the applications of an intersectionality perspective were quite similar for the two NGOs make me believe that these findings can give some indications regarding applications of an intersectionality perspective by civil society organizations in Ghana at large. However, as described in the analysis, intersectionality issues are highly contextual, why caution with generalizations is needed.

The results of this study show that the NGOs' recognition of intersectionality comes from contextual knowledge rather than theoretical. I find that this finding contributes to the critical discussion of intersectionality as nothing more than "old wine in new bottles" (Lutz et al, 2011 p.2). This critique refers to the fact that the ideas, which intersectionality rests upon, have shaped gender studies long before the concept existed (Ibid p.2). It lifts the question of the purpose of intersectionality as a theoretical perspective. One could argue that intersectionality is just another one of those academic labels on an already familiar way of thinking. This questioning might be even greater when adhering to my basic definition of an intersectionality perspective. The usefulness of an intersectionality perspective in the practical work by organizations was also raised several times during the study. The Coordinator for ISODEC's Northern Ghana Programme for instance pointed out that the concept seemed to expose the complexity in development issues rather than prescribing a solution to a problem (2012-02-27). Furthermore, while my study has shown that there are some signs of an intersectionality perspective being applied in certain respects of the NGOs' health work and while there is a vast recognition of the importance of women's intersecting identities, my impression is that the ideas of intersectionality are difficult to conform into practical measures and strategies. The theoretical character of the perspective has also made my search for practical applications difficult. Thus, asking relevant and enlightening questions about such a complex concept was a challenge throughout. However, regardless of the ideas of intersectionality being new or old within gender studies and regardless of the challenges surrounding translating a theoretical perspective into practices, I personally believe that practising the ideas of intersectionality should be sought by development organizations as well as any other actors emphasizing gender awareness. Because of this and because of my findings of applications of an intersectionality perspective, I find that intersectionality has more areas of use than as an analytic tool. The fact that my study had a, compared to other



intersectionality studies, non-traditional purpose and method could in itself widen the scope of the usage of intersectionality as a perspective. The indications of an intersectionality perspective within certain strategies and the recognitions of the staff are also interesting insights of ways of practicing intersectionality perspectives. Development organizations and civil society's influence in policy development and advocacy in Ghana makes CEDEP and ISODEC's relation to the ideas of intersectionality all the more interesting. Since an intersectionality perspective is not officially adopted by the NGOs, the chance of a national spread of the perspective might be limited, although not impossible.

My findings indicate that the perspective is the most useful when a broad range of contextual categories are being addressed. The study thereby makes a contribution to the discussion of whether there should be an open-endedness to the addition of previously missed or newly emerging social categories in relation to intersectionality. The usefulness of interviews as a method to search for applications of an intersectionality perspective within NGOs' work has also been tested in this study. As mentioned, performing these interviews was not always easy. Making sure that I was actually investigating and asking questions about intersectionality and not just social inequalities was a constant struggle. Being a western student studying a concept funded in a western context also required me to think about and adapt my vocabulary. Because of the situated knowledge of me as a researcher it is however likely that others' interpretations would bring forward other results. Nevertheless, I do believe that interviews are necessary tools if one is to study ways in which development organizations with a gender perspective perceive and act upon intersectionality issues.

The results indicated a scattered and somewhat limited application of an intersectionality perspective by the NGOs. This could have many causes. One thing I sensed when talking to the staff was a need to prioritize addressing gender inequalities as such since these are more nationwide and in some settings very visible. For instance, staff members mentioned communities where no women are allowed to take part in any public assemblies. I also sensed that prioritization of other important approaches and in some cases lack of awareness was causing this result. Moreover, I was told by one staff member that incoherence in values within the organization made it difficult to address discrimination of certain identities. To delimit myself in this study I have chosen not to address the influence which foreign as well as national donors might have on the NGOs' knowledge and applications of an intersectionality perspective. It is however clear that international development and gender discourses shape these organizations in terms of working approaches. The fact that intersectionality is formally absent in CEDEP and ISODEC's vocabulary could therefore be related to their donors' priorities. On the other hand, the general absence of articulated intersectionality perspectives among development organizations makes it difficult to say something convincingly about the matter. Apart from external donors' priorities, national actors also influence the work of the NGOs. Going through documentation from the ARHR's Family Reproductive Health Programme, I noticed that national gender policies and priorities were mentioned as a guiding light for their work alongside international gender discourses (FRHP, 2000b p.4).

While this might affect the presence of an intersectionality perspective, it is, as with the external donors, not possible for me to draw any conclusions.

My definition of an intersectionality perspective has shaped my data collection as well as my analysis. As mentioned earlier, in order to make the study manageable, some theoretical aspects of intersectionality are not illuminated by the definition at hand. However, even though aspects of intersectionality, such as the recognition of discrimination not being static but dynamic in relation to different identities depending on time, place and interaction, has been somewhat outside of my scope, some of the findings can be related to it. For instance, some of the women depicted as marginalized or discriminated by the NGOs were not so in all situations. Women who were said to be treated badly by health staff because of their rural identity were not said to encounter this particular discrimination within their own rural community. In these communities it was rather their identities as married women and their relation to their husbands that the staff expressed as making them experience social inequality and bad treatment there. The note that younger women and women without childbirth experience were somewhat discriminated and excluded in community health groups, but not described as discriminated in relation to health staff, also suggests that different forums and locations strengthen women's marginalization. While these examples are extracted from the material; questions and responses concerning this dimension of intersectionality were never explicitly posed to and given by the interviewees. Therefore, it is difficult to claim these analyzes to be indications of the organizations' recognition of the broader scope of intersectionality and not just depictions of the intersectionality context in Ghana. Yet, I consider the findings interesting, not least as a starting point for further and expanded studies of intersectionality perspectives where more dimensions and ways of addressing intersectionality issues in a local context could be investigated.

## 7 Executive Summary

The ideas of intersectionality have informed feminist and gender research during the past couple of decades. In short, intersectionality refers to the notion that women's different identities, such as gender, race and sexuality interact and shape their experiences and power positions. While a lot of controversies surround both the theoretical and methodological aspects of intersectionality, the concept has gained ground inside and outside of the academic sphere. Within the international community, intersectionality is increasingly emphasized as an important element of the gender equality agenda. At the same time, gender awareness is becoming more and more significant to the work of development organizations. The extent to which the organizations' work is influenced by an intersectionality perspective is however uncertain as it has not been extensively studied. While intersectionality most often is used as an analytic tool rather than a practical perspective, I find women's intersecting identities crucial in the social inequality present in most developing contexts, why these issues need to be addressed by development organizations. This makes a case for finding out if and how these kinds of organizations deal with intersectionality issues.

Ghana is a country with great demographic diversity and is experiencing great health challenges, particularly in terms of maternal health. In my study, I have examined two Ghanaian non-governmental development organizations' health work for women with the purpose of finding signs of an intersectionality perspective. By doing so I wished to contribute to the discussion about the role and utility of intersectionality and bring forward new insights from a local perspective. My ambition was also for the study to illuminate interesting aspects of the relationship between gender discourses and practices. The two organizations were *Centre for the Development of People (CEDEP)* and *Integrated Social Development Centre (ISODEC)*. Both were relatively big in size and worked across the country, primarily within the areas of education and health. They shared similarities in working methods and both emphasized gender awareness throughout their work. Using a case study method, I studied the NGOs' approaches, strategies and methods as well as their recognition of intersectionality issues within the field of health. I gathered the material from interviews with staff members and representatives from affiliated NGOs, documentations such as project reports and field observations. The material has subsequently been analyzed to find out in what way there is recognition, within the NGOs, of women's intersecting identities shaping their position in society in general and their health situation in particular. It has also been analyzed to find out in what way there is recognition of women's intersecting identities shaping inequalities and discrimination among women in terms of health and access to health care. My

explicit purpose was to see in what ways an intersectionality perspective is applied in Ghanaian NGOs working with women's health.

It was early on apparent that the organizations' work is influenced by international gender and development discourses in terms of approaches and strategies such as gender mainstreaming and participatory methods. Intersectionality perspectives did not seem to have the same clear impact on the work and the concept of intersectionality was neither mentioned in the organizational documentation nor known by the staff members. Gender was also portrayed by the NGOs as one of the most crucial identities for determining one's vulnerability and women were seen as a collectively vulnerable group. There was however, within the organizations, a generally vast recognition of women's intersecting identities shaping their health positions and discrimination. This recognition is not a product of theoretical knowledge but of a contextual one. Some elements of CEDEP's and ISODEC's work indicated that the ideas of intersectionality were there. The organizations' strategies for creating inclusive health projects were the most prominent examples of the presence of an intersectionality perspective. These strategies recognized the diversity of different groups of women and served to illuminate the experiences of all women and strengthen the voices of the most marginalized ones. Age separated group discussions and door-to-door awareness rising were examples of these strategic efforts. Both organizations used different methods depending on which people to target and to some extent designed their project activities and meetings to give voice to women with different intersecting identities. It was nonetheless occasionally difficult to distinguish between their ambitions and their actual strategies. Another indication of an intersectionality recognition among the staff was the fact that the women depicted as marginalized or discriminated were not so in all situations and different identities were said to make the women vulnerable in different situations. This is in line with intersectionality's notion of discrimination as not being static but dynamic in relation to different identities depending on time, place and interaction.

Some other strategies and methods also recognized and addressed particularities among women's health situations and experiences caused by their intersecting identities or were at least compatible with an intersectionality perspective. However, most of them were not and others were doubtful. Similarly, strategic efforts taken by the NGOs to create broad representation and participation could indicate presence of the ideas of intersectionality, but it could also be seen as a general ambition to include as many community members as possible. Present study also suggests that while many intersecting identities and inequalities seem to be addressed, some were not. For instance, measures taken to address the health situation of stigmatized women such as homosexuals and to some extent women living with HIV/Aids or disabilities were few.

Discussions of intersecting identities affecting women's health situations revealed that the common intersecting categories of identities were not completely relevant in these Ghanaian contexts. Instead of traditional intersectionality categories based on ethnicity, religion, class and sexuality; rural women, married women and women from certain cultures were among the categories most often

mentioned as marginalized by the NGOs. This makes a case for an open-endedness to the addition of previously missed or newly emerging social categories to the traditional intersecting categories of identities, something which is academically debated. If not, I find that the possibility of a practical and universal use of an intersectionality perspective is limited.

Distinguishing CEDEP's and ISODEC's work and perspectives from the ones of their project implementing partners and/or funding organizations was not totally easy. However, the findings suggest that the two NGOs had about similar applications of an intersectionality perspective, why the results could say something about its presence among NGOs in Ghana at large. To some extent, the organizations implied a need to prioritize addressing gender inequalities as such, rather than intersecting identities, since these were more visible and explicit. Both organizations did also frequently emphasize practicalities or practical circumstances together with identities as crucial for women's health. This highlights the complexity of women's health challenges and the need for practitioners to work with many dimensions of the problem rather than with one perspective. The study also showed the difficulties in practising a theoretical perspective such as intersectionality. Even if there were recognition of women's intersecting identities' importance, applications of an intersectionality perspective were often not. Yet, the study can be seen as a contribution to the many ongoing discussions about intersectionality, inside and outside of the academic world. It is also likely that an extended study with more field observations, an expanded interview base and a more explicit definition of intersectionality perspective would further deepen the knowledge and understanding of the role of intersectionality within the work of development organizations.

## 8 References

- Aboba, Mathias, 2011. "Ghana: ISODEC Tackles Cultural Barriers to Maternal, Child Health Care". Link 2012-07-15: <http://allafrica.com/stories/201109091441.html>
- Ackerly, Brooke – True, Jacqui, 2008. "Reflexivity in Practice: Power and Ethics in Feminist Research on International Relations". *International Studies Review*, Vol. 10, No. 4, P. 693-707.
- ARHR, 2009. "Internal midterm evaluation of EKN support for the ARHR and the end of term support of SIMAVI for the FRHP of ISODEC (Draft report 12/8 2009)".
- ARHR, 2008. "Reproductive Health Training Manual for Health Advocacy and Accountability Project". Sponsored by the Embassy of the Kingdom of Netherlands.
- ARHR, 2007. "Social Analysis for Citizen's Action and Health MDGs Project (ARHR)".
- ARHR, 2006. "Alliance for Reproductive Health Rights (ARHR) rights-based approach workshop (30<sup>th</sup> and 31<sup>st</sup> October, 2006)-Erata Hotel, East Legon".
- Asante, Richard – Gyimah-Boadi, E. 2004. "Ethnic Structure, Inequality and Governance of the Public Sector in Ghana". Link 2012-07-15: <http://unrisd.org/unrisd/website/document.nsf/%28httpPublications%29/8509496C0F316AB1C1256ED900466964?OpenDocument>
- Baden, Sally - Green, Cathy - Otoo-Oyortey, Naana – Peasgood, Tessa, 1994. "Background paper on gender issues in Ghana". Link 2012-07-15: [www.bridge.ids.ac.uk/Reports/re19c.pdf](http://www.bridge.ids.ac.uk/Reports/re19c.pdf)
- Beijing Declaration and Platform for Action, 1995. Fourth World Conference on Women. Link 2012-07-15: <http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf>
- Berger, Michele T – Guidroz, Kathleen, 2009. "A Conversation with Founding Scholars of Intersectionality – Kimberlé Crenshaw, Nira Yuval-Davis and Michelle Fine", P.44-61, in Berger, Michele T – Guidroz, Kathleen (eds), 2009. *The Intersectional Approach: transforming the academy through race, class and gender*. North Carolina: The University of North Carolina Press.
- CEDEP, 2012a. "About us". Link 2012-07-02: [http://cedepghana.org/index.php?option=com\\_content&view=article&id=89&Itemid=74](http://cedepghana.org/index.php?option=com_content&view=article&id=89&Itemid=74)
- CEDEP, 2012b. "Report on Community Rally to Demand Improved Health Care Delivery held in Dormaa Municipality under the Health Advocacy and Accountability Project, 27<sup>th</sup> January 2012".

- CEDEP, 2011a. “Draft Report on Advocacy and Communication Training held in Sekyere East District under the Health Advocacy and Accountability Project, 29<sup>th</sup> June 2011”.
- CEDEP, 2011b. “Draft Report on Advocacy and Communication Training held in Dormaa Municipality under the Health Advocacy and Accountability Project, 30<sup>th</sup> June 2011”.
- Colorado State University, 2012a. “Case studies”. Link 2012-04-16: <http://writing.colostate.edu/guides/research/casestudy/com2a1.cfm>
- Colorado State University, 2012b. “Method: Single or Multi-modal?”. Link 2012-04-16: <http://writing.colostate.edu/guides/research/casestudy/pop3a.cfm>
- Colorado State University, 2012c. “Case Study: Concerns about Validity, Reliability, and Generalizability”. Link 2012-04-16: <http://writing.colostate.edu/guides/research/casestudy/pop4b.cfm>
- Crenshaw, Kimberle, 1991. “Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color”. *Stanford Law Review*. Vol. 43, No. 6, P.1241-1299.
- Crenshaw, Kimberle, 1989. “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics”. *The University of Chicago Legal Forum*. Link 2012-07-12: <http://www.scribd.com/doc/59912037/Demarginalizing-the-Intersection-of-Race-and-Sex>
- Davis, Kathy, 2008. “Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful”. *Feminist Theory*. Vol. 9, No.1, P. 67-85.
- Degele, Nina – Winker, Gabriele, 2011. ”Intersectionality as multi-level analysis: Dealing with social inequality”. *European Journal of Women's Studies*, Vol. 18, No. 1, P. 51-66.
- EnGenderHealth, 2012. “Ghana”. Link 2012-07-12: <http://www.engenderhealth.org/our-countries/africa/ghana.php>
- Esaiasson, Peter – Gilljam, Mikael – Oscarsson, Henrik – Wängnerud, Lena, 2004. *Metodpraktikan – konsten att studera samhälle, individ och marknad*. Second edition. Stockholm: Norstedts Juridik AB.
- FRHP, 2000a. “Programme Review Committee Meeting of the FRHP, September 11 2000”.
- FRHP, 2000b. “The Family Reproductive Health Programme supplementary report on the extent of integration of gender into programme”.
- FRHP, 1999. “Family reproductive health programme review and dissemination workshop Kokrobite II. Volume II. Venue: SECAPS Hotel, Accra. February 22-24, 1999”.
- Ghana Statistical Service, 2008. “Ghana Demographic and Health Survey 2008 – preliminary report”. Link 2012-07-12: [http://pdf.usaid.gov/pdf\\_docs/PNADO176.pdf](http://pdf.usaid.gov/pdf_docs/PNADO176.pdf)
- Ghana Statistical Service, 2004. *Ghana Demographic and Health Survey 2003*.
- GhanaWeb, 2012. “Ethnic Groups”. Link 2012-07-15: <http://www.ghanaweb.com/GhanaHomePage/tribes/>

- Ghana Ministry of Health, 2011. "Ghana Human Resources for Health Country Profile". Link 2012-05-14: [http://www.hrh-observatory.afro.who.int/images/Document\\_Centre/ghana\\_hrh\\_country\\_profile.pdf](http://www.hrh-observatory.afro.who.int/images/Document_Centre/ghana_hrh_country_profile.pdf)
- Haraway, Donna, 2008. "Situated Knowledge: The Science Question in Feminism and the Privilege of Partial Perspective", P.346-352 in Jagger, Alison M (ed), 2008. *Just Methods – An Interdisciplinary Feminist Reader*. Colorado: Paradigm Publishers.
- ISODEC, 2012. "About Us". Link 2012-07-10: <http://www.isodec.org.gh/aboutus.php>
- ISODEC, 2011. "Top Project June Report".
- Kerr, Joanna, 2001. "International trends in gender equality work". Association for Women's Rights in Development. Link 2012-07-15: <http://www.awid.org/Library/International-trends-in-gender-equality-work>
- Kingma, Koos - van der Hoogte, Liesbeth, 2004. "Promoting Cultural Diversity and the Rights of Women: The Dilemmas of 'Intersectionality' for Development Organisations", *Gender and Development*, Vol. 12, Nr. 1, P.47-55.
- Kwapong, O. A. T. F., 2008. "Commentary: The health situation of women in Ghana". Link 2012-07-15: [http://www.rrh.org.au/publishedarticles/article\\_print\\_963.pdf](http://www.rrh.org.au/publishedarticles/article_print_963.pdf)
- la Rivière-Zijdel, Lydia, 2009. "The Ignored Aspects of Intersectionality", P.31-44, in Bagilhole, Barbara M – Cabó, Anna – Franken, Martha – Woodward, Alison (eds), 2009. "Teaching Intersectionality – Putting Gender at the Centre". Link 2012-07-12: [http://www.erg.su.se/polopoly\\_fs/1.39115.1320403014!/Teaching\\_Intersectionality.pdf](http://www.erg.su.se/polopoly_fs/1.39115.1320403014!/Teaching_Intersectionality.pdf)
- Lang, Kanika – Porter, Fenella, 2006. "Resources on Working on Gender with Marginalised Peoples". *Gender and Development*, Vol. 14, No. 2, P. 291-305.
- Lutz, Helma – Supik, Linda – Vivar, Maria T.H, 2011. "Framing Intersectionality – An Introduction, P.1-24, in Lutz, Helma – Supik, Linda – Vivar, Maria T.H (eds), 2011. *Framing Intersectionality – Debates on a Multi-Faceted Concept in Gender Studies*. Farnham: Ashgate Publishing Limited.
- Lykke, Nina, 2010. *Feminist Studies: A Guide to Intersectional Theory, Methodology and Writing*. New York: Routledge.
- Matsuda, M. J, 1991. "Beside My Sister, Facing the Enemy: Legal Theory out of Coalition", *Stanford Law Review*, Vol. 43, No. 6, P. 1183–92.
- Morley, Louise, 2010. "Gender mainstreaming: myths and measurement in higher education in Ghana and Tanzania", *Compare: A Journal of Comparative and International Education*, Vol 40, No 4, P.533-550. Link 2012-07-15: <http://www.tandfonline.com.ludwig.lub.lu.se/doi/pdf/10.1080/03057925.2010.490377>
- Oxfam, 2011. "Top Project Proposal Template 2011/12".
- Oxfam International, 2011. "Achieving a Shared Goal: Free Universal Health Care in Ghana. Executive Summary". Link 2012-07-15: <http://www.isodec.org.gh/Publications/Featured/Summary.pdf>



- Riley, J, 2004. "Some reflections on gender mainstreaming and intersectionality", *Development Bulletin*, No. 64. Link 2012-07-15: [http://devnet.anu.edu.au/GenderPacific/pdfs/19\\_gen\\_mainstream\\_riley.pdf](http://devnet.anu.edu.au/GenderPacific/pdfs/19_gen_mainstream_riley.pdf)
- Shields, Stephanie A, 2008. "Gender: An Intersectionality Perspective", *Sex roles: a journal of research*, Vol. 59, No. 5, P.301-311. Link 2012-07-15: <http://www.springerlink.com.ludwig.lub.lu.se/content/d18gn231052j14w7/fulltext.pdf>
- Takyi. B. K, 2003. "Religion and women's health in Ghana: insights into HIV/AIDs preventive and protective behavior". Link 2012-07-15: <http://www.ncbi.nlm.nih.gov/pubmed/12600360>
- The Swedish Institute of International Affairs, 2012. "Landguiden – Ghana". Link 2012-07-15: <http://www.landguiden.se/Lander/Afrika/Ghana>
- UNICEF, 2012. "At a glance: Ghana". Link 2012-07-15: [http://www.unicef.org/infobycountry/ghana\\_statistics.html](http://www.unicef.org/infobycountry/ghana_statistics.html)
- Wong, Jane, 1999. "The Anti-Essentialism v. Essentialism Debate in Feminist Legal Theory: The Debate and Beyond", *William & Mary Journal of Women and the Law*. Vol.5, Issue 2. Link 2012-07-13: <http://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=1243&context=wmjowl>
- Yin, Robert. K, 2009. *Case study research: Design and Methods*. Fourth edition. Thousand Oaks: SAGE Inc.
- Yin, Robert. K, 1984. *Case study research: Design and methods*. Newbury Park: Sage.

# 9 Appendix

## 9.1 List of Interviewees

1. CEDEP Health Manager (2012-01-20)
2. Municipal Director of Health Service, Offinso (2012-01-26)
3. Representative from Centre for Maternal Health and Community Empowerment (CMCE), local project partner organization in Dormaa (2012-01-27)
4. Community nurse, Dormaa (2012-01-27)
5. CEDEP Assistant Programme Officer (2012-02-02), email response (2012-03-05)
6. CEDEP Education and Health Programme Manager (2012-02-06)
7. ISODEC Coordinator of Social Services Campaign (2012-02-17)
8. ISODEC Policy Analyst (2012-02-22)
9. ISODEC Volunteer (2012-02-24)
10. ISODEC Coordinator for the Northern Ghana Programme (2012-02-27)
11. Representative from Integrated Development and Health Centre, local project partner organization in Bolgatanga (2012-03-13)
12. ISODEC Former Top project Coordinator (changed position during my time in Ghana), email response (2012-05-07)

## 9.2 Interview Template

Since no interviews were identical and since the questions were adjusted during the interviews, this template is just to give an idea of the interviews' character and content.

1. Would you like to tell me about your professional background and your position here at CEDEP/ISODEC?
2. Could you briefly describe CEDEP/ISODEC as an organization, in terms of overall strategies and objectives?
3. Could you briefly describe the X project/s, what is it/are they about?
4. Which actors/stakeholders are involved in the project? How is it funded?
5. Can you tell me a little about the demography of the region in which the project is situated, in terms of religion, ethnicity, income level etc, is it diverse or homogenous?
6. Do you know of any local tensions (even in a trivial sense) between groups in the area? Does for example discrimination towards ethnic minorities occur? And if yes, do you think that affects women's health issues in any way?
7. What is the responsibility of CEDEP/ISODEC in this project and what is the responsibility of the local co-implementing NGO? Which organization is responsible for inviting and mobilizing people to participate in the project activities? Are there any requirements/criteria from CEDEP/ISODEC related to the participation?
8. Is the project/projects' aim to get involvement from *all* women or from a certain group of women more than others? And why?
9. What would you say is important to consider when wanting to reach/help this/these groups of women?
10. Are there any concrete strategies or methods used by CEDEP/ISODEC in order to get participation from all kinds of women/as many women as possible in these projects? Do you use the same method to get different groups of women to participate in the health projects?
11. Are there challenges in trying to make certain women participate in the project/s? (For instance, because they do not want to participate, or because they are not allowed to participate, or because they do not have time to come, or because they were not informed about the activity?).
12. Are women with different backgrounds/identities involved in the project activities?
13. In what way are Rights-based approaches/Participatory methods influencing the health work of CEDEP/ISODEC?
14. Are some women in Ghana and in the project region/s more marginalized and experiencing greater barriers to access health care than others?
15. Which women would you say face the greatest challenges to have good reproductive health and access their reproductive rights in the project region/s and in Ghana in general? (In terms of identities and backgrounds such as age, social status, marital status, religion, ethnicity, sexuality, education etc.)

16. Have you come across any cases of discrimination against certain women in terms of accessing health care, meeting with the health service or the traditional birth attendants? For instance women who are stigmatized?
17. Have you heard of the concept of intersectionality before? Is it an approach which CEDEP/ISODEC make use of in some way in its projects or policies?
18. What is the most important ingredient in a project for improvement of women's health?