Women's Fears and Men's Anxieties: The Impact of Family Planning on Gender Relations in Northern Ghana

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The Navrongo experiment, a family planning and health project in northern Ghana, has demonstrated that an appropriately designed, community-based family planning program can produce a change in contraceptive practice that had been considered unattainable in such a setting. Simultaneously, however, evidence suggests that newly introduced family planning services and contraceptive availability can activate tension in gender relations. In this society, where payment of bridewealth signifies a woman's requirement to bear children, there are deeply ingrained expectations about women's reproductive obligations. Physical abuse and reprisals from the extended family pose substantial threats to women; men are anxious that women who practice contraception might be unfaithful. Data from focus-group discussions with men and women are examined in this report and highlight the strains on gender relations resulting from contraceptive use. The measures taken to address this problem and methods of minimizing the risk of adverse social consequences are discussed. (STUDIES IN FAMILY PLANNING 1999; 30[1]: 54–66)

That family planning programs can affect contraceptive behavior and fertility positively is widely accepted.[1] That appropriately designed and implemented family planning programs can have positive effects even in adverse social and cultural settings is also beginning to be established. The Matlab Maternal and Child Health and Family Planning Project has received widespread international recognition for demonstrating such results in a conservative, traditional, remote, and economically disadvantaged region of rural Bangladesh (Phillips et al. 1988). Subsequently, the national family planning program also showed remarkable results (Cleland et al. 1994). More recently, a family planning and health experiment in the Kassena-Nankana District of northern Ghana appears to show that an impact on contraceptive use and fertility can be produced under conditions where such results had been considered unattainable (Debpuur et al. 1999). Since the Navrongo experiment was launched in Ghana in 1994, contraceptive prevalence has increased in all experimental areas; as a result, in 1997, total fertility declined in each of the treatment areas by 0.5 births while remaining constant in the comparison areas.

A strategically organized public-sector health and family planning intervention in Navrongo mobilized local resources and social organizations in the effort to bring education and health-care services to village residents in the area (Nazzar et al. 1995). This strategy of aligning a family planning intervention with traditional social organizations succeeded in generating community support and acceptance of family planning education and services in rural communities. However, as the effects of contraceptive use are beginning to emerge in Navrongo, evidence also suggests that the introduction of family planning has activated tensions in gender relations.

The emergence of such tension is not surprising. Modern means of managing fertility give women a degree of reproductive autonomy that they did not have

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in the past. Such autonomy, no matter how slight, upsets the prevailing power relationships between men and women and threatens to disturb deeply ingrained expectations about women's reproductive obligations (Adongo et al. 1997).[2] Using data from focus-group discussions with women, men, and community leaders held over a three-year period (1994–96), this report seeks to identify and describe the strains in gender relations associated with increased availability and accessibility of modern contraceptives in Navrongo.[3] These tensions are frequently mentioned by focus-group participants, but they do not characterize all spousal relationships. Availability of modern means of contraception can also improve relations between husbands and wives because these methods improve the satisfaction of sexual desires and aid in the attainment of reproductive goals. Nonetheless, tensions in gender relations are noted persistently enough to warrant attention, further exploration, and appropriate programmatic responses.

Social research concerning the introduction of family planning into traditional societies consistently demonstrates that the fears and concerns documented here are widespread in African countries characterized by extreme forms of gender inequality.[4] In sub-Saharan Africa, husbands tend to want larger families than do their wives (see Bankole and Singh 1998). This gender differential may lead to conflicting feelings about family planning. Qualitative studies in Kenya and Zambia have revealed that women are afraid to ask their husbands' permission to use a family planning method. If they practice family planning without their husbands' consent, they worry about being discovered (see Brown et al. 1990; Biddlecom and Fapohunda 1998). In Nigeria, women fear that they may be forced to leave their husbands' homes if they are caught (Renne 1993). Some worry that a contraceptive's side effects will expose their secret use to their husbands (Rutenberg and Watkins 1997). In Uganda, disagreement between husbands and wives carries a high social cost, including violence, divorce, or a husband's "bringing in" another wife (Blanc et al. 1996).

In this report, these concerns are documented in the context of the Navrongo experiment; programmatic action to address them is discussed, and the need for research and program interventions is suggested.

Methodology

This study is based on a series of three investigations that generated a total of 36 focus-group discussion sessions between 1994 and 1996. The overall aim of the investigation was to monitor community reactions to the Navrongo experiment and to advise project investigators about perceived problems and necessary changes. In 1994, a baseline study investigated reproductive norms and beliefs of the Kassena-Nankana people. It was designed to assist staff in anticipating problems that could arise from the project (Adongo et al. 1997). Two sessions each were convened for older men and older women (aged 40–65) and younger men and younger women (aged 20–39); two sessions were conducted with "opinion leaders," men and women known to be influential in the study villages by virtue of their political, social, or educational standing. Male participants for this group were selected at random from a list of chiefs, elders, subchiefs, teachers, and elected assemblymen. Female opinion leaders were chosen at random from a list of leaders of women's political organizations and social groups and wives of prominent leaders. Thus, ten focus-group discussions were convened in 1994 with panels comprised of married women, married men, and opinion leaders.

In 1995, a further investigation was undertaken by means of focus-group discussions after pilot activities of the Navrongo experiment had been launched (Nazzar et al. 1995). In this round, ten group discussions were conducted in order to gauge community reactions to service-delivery activities in three trial villages where experimental family planning services had been in operation for six months. Two sessions each were convened among young men, old men, young women, and old women, with age classes defined according to the 1994 study criteria. Two sessions were convened for opinion leaders. Half of the participants in the sessions with old men were also heads of compounds.

Focus-group discussions were repeated in 1996 after the experiment had been scaled up to a districtwide initiative. However, panels with opinion leaders were dropped, because the purpose of convening leaders had been satisfactorily addressed in the 1995 sessions with old men and old women. The discussion groups were convened in villages dispersed over the four experimental areas of the project, with participants classified by age and gender, as in the 1994 and 1995 studies, generating a total of 16 sessions. Because of changes in the sampling strategy for each of the rounds, some villages were included in two or three rounds, whereas others participated only in one. As a result, some villages are more frequently represented than are others in the quotations presented here.

In all three investigations, purposeful sampling was used to select participants for the sessions; care was taken to separate the groups into homogeneous types of respondents from different lineages. Also, measures were taken to ensure privacy in the course of group sessions. All interviews and sessions were conducted, re-

corded, and transcribed in the dialects of the study villages. All sessions and interviews were translated into English, and session responses were manually sorted by response type and theme to clarify the content of responses and reactions to project activities.

In 1995 and 1996, the groups with men and with women were designed to elicit discussion of reactions to the project, of perceptions of its benefits or detriments, and of the meaning and acceptability of family planning. All sessions incorporated questions that touched upon gender relations, such as: "Some women can discuss family planning with their husbands, but some women may not be able to do so. What are the reasons?" or "Some women may want to practice family planning but may not feel free to do so. Why?" However, the purpose of these sessions was not to study gender-related tensions arising from the practice of family planning, but rather to evaluate community reactions to the Navrongo experiment.

Women's Interest in Contraceptive Use

Although at the onset of the Navrongo experiment contraceptive use was extremely low, evidence suggests that some support for fertility regulation existed among both men and women at that time and that such interest is increasing. Unmet need for family planning was estimated at 33 percent in 1996 (Biddlecom et al. 1997). Such interest in contraceptive use appears to be stronger among women than among men; at least women are more willing than men to talk about it. Survey results indicate that this interest is almost entirely a desire to space rather than to limit future childbearing. Focus-group discussions also indicate some social approval of limiting.

Child spacing is greatly valued in this rural society, as it is in other parts of sub-Saharan Africa, and women in particular prize it (Ezeh 1991; Caldwell and Caldwell 1981; Caldwell and Caldwell 1987). Abstinence is the preferred means of assuring long birth intervals because of the traditional belief in the incompatibility of mother's milk with semen (Schoenmaeckers et al. 1981). Faced with the obligation to fulfill their husband's sexual desires, however, women find in modern methods of contraception the means of attaining the degree of spacing that they value so highly. For example, one young woman said:

> Family planning has actually helped us. Now, you can let your child grow to three to four years before you have another child, but before this, people could not wait this long before they became pregnant. (Kologo village)

Contraception permits spacing without risking spousal discord or the threat of violence associated with coital refusal:

> In Naga, if you want to have ten children, you can do that, but you need to make sure there are intervals between the births of your children. Even when you tell your husband that you would not like to have another child (yet), he will tell you that he paid the bridewealth, so that he can have children with you and that you have no right to tell him not to have sex with you. If you still insist, he beats you up. But would you allow him to continue beating you every day? No. You will go and use a method, so that he can have sex with you while you plan your family. (Old woman, Naga)

According to this woman, men want both children and sex and may enforce their desires with violence. In the face of such pressure, contraceptive use gives women a means of pursuing their own reproductive strategies, which emphasize spacing. This theme is reiterated by young women in Kologo as well, who make clear that given their powerlessness to resist their husbands' pressure to have sex, contraception is a valuable tool:

> *Interviewer:* Do you know any method people use in this area for preventing pregnancy?
>
> *Woman 1:* There is and there is nothing. Why do I say that? Everything depends on you, the woman, because you know the problems you face. So you have to protect yourself. Whether the children get to eat, go to school or not, and even when they are sick, it is the woman's burden. The man knows least what is happening. When you are facing these (situations), then you have to seek family planning to protect yourself and your children.
>
> *Interviewer:* How will you protect yourself from getting pregnant?
>
> *Woman 1:* Well, at night if he is disturbing you, tell him to go away. (*Everyone laughs*)
>
> *Woman 2:* You are lying. The only way you now protect yourselves is by using family planning methods. Before the advent of planning, most of you used to get pregnant when your children were just about crawling. You as a woman have no power over your husband, so how can you tell him to go away at night. Family planning is now helping most of you to space your birth at least three to four years before you have another child.

Women's interest in fertility regulation is also motivated by child-care responsibilities, which they perceive to fall entirely on their shoulders and which they perform under conditions of extreme deprivation:[5]

> If you give birth to six or seven children and they start crying from hunger and do not have anything to eat, what will you do? And if the child goes to the father and says (s)he is hungry, he will say: 'Go to your mother.' [I say] 'Which part of my body do you want me to cut and cook for the child? I don't have anything in my room.' So if a woman wants to practice family planning and the nurse knows she can provide a method for her, she should do so and leave the woman's husband [out of the picture], because it is the women who take care of the children. It is not the men who take care of the children; all suffering is with the women. The man will say he is for [having] the child; meanwhile it is the woman who is suffering. (Young woman, Naga)

This young woman declares that women have the right to adopt family planning on their own, disregarding their husbands' interests, given women's responsibility for children and the hardship that caring for them entails.

Women's Fear of Opposition and Reprisal

Although contraceptive use may reconcile men's sexual desire and women's interest in spacing, it also generates marital discord, the physical abuse of wives, and the opposition of other family members.

Wife Beatings

Fear of violence is neither rare nor unfounded among Kassena-Nankana women. Violence was discussed frequently in the focus groups in connection with women's refusal to engage in sexual relations.

> If a woman is not experiencing her menses and is not sick, she has no right to refuse sex, because we marry her to have children, and that is how we can get children. We don't marry women for their cooking. So if she refuses to have sex, why won't I want to beat her? I will beat her. (Male opinion leader, Kologo)

The theme that family planning can precipitate men's disapproval and violence was of equal importance:

> Some men understand you when you discuss family planning with them, but there are some with whom you start the topic and immediately a quarrel follows. This is why some of us cannot discuss family planning freely with our husbands. (Young woman, Kologo)
>
> If you discuss [family planning] with some men, they will get up and beat you. (Young woman, Kayoro)
>
> It is also true that, when the women refuse to have sex with them, they go outside for other girls. When the women also go to adopt a method of family planning, they beat them. (Old woman, Naga)

Survey results from Navrongo confirm that violence against women is considered justified in many situations by a large proportion, although not always the majority, of both male and female respondents.[6] Fifty-one percent of female and 43 percent of male respondents agreed that a husband is justified in beating his wife when she uses a family planning method without his knowledge; 43 percent of female and 33 percent of male respondents agreed that beating a wife is justified if she refuses to have sex (Biddlecom et al. 1997). Wife-beating was also perceived as legitimate if a woman fails to cook for her children or travels without her husband's permission. More women than men responded that wife-beating was justified in each of these scenarios, reflecting women's perceptions of social norms concerning violence and their acceptance of male decisionmaking authority.

Loss of Intimacy and Affection

Some women also fear that their husbands' disapproval of contraceptive use can lead to withholding affection or sex or their preference for another wife. The threat of such disapproval is serious, especially in a polygynous society with weak conjugal bonds and a high degree of separateness among spouses (Abu 1983). Sometimes family planning is perceived as a rival that interferes with harmonious spousal relationships. It may even be considered grounds for divorce:

> You can even cook food and keep it for him and then [tell the child to call him], and he will say 'Go and tell her I don't want her food. She should take it and eat [it] with her family planning.' (Young woman, Naga)
>
> If someone goes and injects, her husband will say in the night: Because you have gone to do family planning, I will not have sex with you; you should have sex with yourself. (Young woman, Naga)
>
> If your husband does not approve of it and you still go to practice, he can divorce you. He will

> even tell your parents that it is not because of family planning that he married you, and because you have gone to use a method without his knowledge, he has divorced you. This can result in a serious quarrel between you. (Old woman, Naga)

When measured against the threat of losing a husband's affection, giving birth to more children may appear preferable, especially when a woman must compete for her husband's affection with other wives:

> If my husband marries a second woman and he does not want us to do [family planning] and she doesn't do it, he will love her; he will not love me again. If he has something small, he will give it to her and leave me, and if day breaks, he will not come to my room too. In the night I will be sleeping alone with all my family planning and he will be with my rival. As for us women, we are jealous. Even if all women are not jealous, as for me, I am. If I see that my husband and my rival are of the same mind, and I am different, I will not agree. I have to leave family planning and become like them so that I will give birth to my children and be happy. (Young woman, Naga)

Cost of Contraception

A nominal fee is charged for all contraceptive services provided in the Navrongo project area. Although small, this fee is perceived as a significant barrier to contraceptive use in these extremely poor communities. As the quotations from two young women of Natuginia below indicate, procuring money for the fee from one's husband can also provoke conflict:

> *Woman 1:* You may want to do it, but you may not have the money for it, and your husband, who disapproves, will not give you the money to do it.
>
> *Woman 2:* If your husband gets his money, he will use it in drinking. You will need money to buy salt, and you will not get it. How are you then getting money to use for family planning when you cannot even get money for salt?
>
> The young women are speaking the truth. These young men have two, three, children but when they get money, they go straight to drink *akpeteshie* [local gin]. They will never give this money to the women to make food for the family. The women will fight them and curse themselves for marrying them, but all to no avail. Instead of giving the money to the women to buy food and some to use for the injection so that it would help them, he will rather use the money to buy drink and come home very drunk every day. The men do not care about their women, and we have spoken and spoken to them countless times, and we are now fed up. (Old woman, Naga)

Resource constraints that place the purchase of contraceptive supplies in competition with buying basics for family survival become all the more acute and stressful when the husband objects to fertility regulation. The fee requirement obligates women to negotiate with their husbands for money for contraceptive supplies. Although the amounts seem small, the emotional costs of pursuing these negotiations can be great.

> Money is our problem. If you have a husband who does not approve of family planning, and you do not have your own money to adopt a method, I do not think you can ever talk him into giving you money for family planning. (Old woman, Naga)
>
> I cannot even speak of family planning in passing to my husband, not to mention trying to discuss it with him. Every morning, whenever he hears people discussing family planning over the radio, he gets so angry and even wishes he could lay a hand on the person speaking. He fumes and shouts, cursing under his breath, that no one can ever tell him to practice family planning because nobody is taking care of his children for him. If he can threaten a wireless, an inanimate thing, what would he do to me if I open the topic? My husband does not understand the family planning concept, and I will never discuss it with him. You can discuss it with husbands who have some amount of understanding, but not my husband. The only solution is, if you have your own money, go and adopt a method without informing him. (Old woman, Naga)

Conflict with Extended Family and Ancestors

The fear of conflict over contraceptive use sometimes extends to other family members:

> Some of our husbands understand, but their mothers and fathers don't agree. Someone like me, my husband gave me [money] and I went and injected for three months. When it was time again and I told him, his mother and father did not agree. His mother did not agree and said

> that I am fooling him by not giving birth for him. Because of that, he did not give me the money, and as I don't have money to go and inject, I am sitting like that and we are fighting. What will I do? (Young woman, Naga)

Even the disapproval of ancestors is feared:

> Some women may want to do it but may not feel free to do so because there is the belief among many women that the ancestors are against such practices, and that one may die or may not get any blessing from the ancestors if she practices those things. (Young woman, Paga)

> If my daughter-in-law wants to practice family planning and informs me, I will tell her that if she encounters any health problems after using a method, she should be ready to suffer for it. I will wash my hands of her. (Old woman, Kologo)

Tensions with members of the extended family are mentioned much less frequently, however, than are tensions with one's husband. Some focus-group participants pointed out that times are changing and that nowadays family members have less influence than they did in the past. This remark confirms that from the women's perspective, tensions regarding contraceptive use arise predominantly in those situations in which husbands disagree with or distrust their wives' intentions, or when women are afraid to raise the topic with their husbands because they fear their disapproval. Contraceptive use is not the only issue; the threat also exists that women might make independent decisions. If women proceed to use contraceptives in the face of their husbands' opposition, they violate deep-seated gender norms that do not permit such autonomy.

Women's Coping Strategies

Focus-group transcripts also show that women are not entirely defenseless in the face of their husbands' disapproval of contraceptive use. This finding supports evidence from studies conducted elsewhere that women adopt "complicated and subtle reproductive and sexual strategies in order to achieve some degree of autonomy and at the same time maintain their place in the family and the community" (Petchesky and Judd 1998: 17). The following quotes illustrate strategies that women use to attain their reproductive goals when faced with situations of conflict:

> When you and your husband are living together and you say something that he does not understand, you have to let the man understand so that your mouths will be one. So that you can follow the way you want. (Young woman, Kayoro)

> If I do not have money and my husband also does not give his consent, I am prepared to go to the bush, gather firewood and take it to the market to sell. Whatever I get out of that I will use to adopt a method to prevent any pregnancy. (Young woman, Kologo)

That such strategies are not entirely new but have been used in the past is reflected in the following quotation in which an older woman describes how she resisted unwanted sexual advances from her husband:

> What we used to do was that, when your child was still a baby and your husband wanted to have sex, you fought him. If he beat you, you screamed for other people to come to your rescue, and they used to scold such men. After such a scene, he would never come to you until the child was old enough. (Old woman, Kandiga)

Another major strategy that women use to protect their interests and to maintain peaceful family relationships is the secret use of contraceptives. Considering the fears that women have about their husbands' or family's reaction to their using a method, their resorting to secrecy is not surprising. Women hide contraceptive use not only from their husbands but also from other women in their community. The reason for such widespread secrecy is fear of reprisal and ridicule:

> If you want to do family planning and you tell your husband, he will say he doesn't want any nurse to come to his house and tell his wife that she should do family planning. So the woman is always suffering. That is the reason why some of us women who want to do family planning do it without consulting our husbands and in their absence. (Young woman, Kayoro)

> People from this area feel embarrassed when they know that other people are aware that they are using a method. So most of the time, they go secretly to do it, and you would not know. They do this because people laugh at those using family planning methods to prevent pregnancy. (Young woman, Kologo)

When data on contraceptive-use status from the management information system of the Navrongo experiment are matched against panel survey data, such secret use can be estimated indirectly (Phillips et al. 1997a). During interviews, husbands are much more likely to deny that their wives are using contraceptives (57 percent) than are women when they are asked about their contraceptive-use status (23 percent). Although such de-

nial may also reflect the husbands' eagerness to maintain secrecy, this finding is, in all likelihood, an expression of their being unaware that their wives are practicing family planning.

Women's secret use of contraceptives is also widely acknowledged by the community health nurses who report that women often prefer to obtain supplies directly from the community health center, rather than at their homes, for this very reason.

Men's Anxieties

The tensions concerning family planning are also felt by men. Some of the anxieties men have mirror those expressed by women. Others differ. Key themes relate to the concern that women will refuse to fulfill their reproductive and sexual obligations, that they will seek sexual satisfaction outside of marriage and possibly abandon their families, that contraceptive use creates conflict among multiple wives, or that a man will lose control of his household if he is not consulted. In more general terms, the possibility that women might act independently is perceived as a threat to the strong, deeply anchored, patriarchal traditions of these communities.

Women's Reproductive and Sexual Obligations

Women's obligation to bear children is the cornerstone of marriage in this rural society where wives are acquired through the payment of bridewealth in the form of sheep and cattle. Women are seen as their husbands' property or as that of their husbands' families, submerged within a corporate identity where individual preferences have no place. Their major function in life is to produce children for their husbands and the lineage. Any indication that women are taking control of their reproductive function suggests to men that women might not wish to live up to their reproductive obligation. The threat of such abrogation of responsibility causes profound anxiety:

> You should know that in this place we marry our women with cows. When my father pays the bridewealth, he did that for you to deliver children for me and build his house for him. If you have one child, maybe the child is a son or a daughter. You know a daughter can't build my house. We feel it is only a son who can build a house. So, if a woman has one child and decides to [stop], there will definitely be a fight, because where am I going to get cattle to marry again? We will fight to her father's house. Her father married her mother to give birth to children that will build his house, but unfortunately she was born female and I have also picked her to build my house, so she must deliver children for me. I know her father will support me. When the matter is settled and she comes back and hatches the children like birds for me, I will like that. (*Laughter*) (Old man, Naga)

> We marry women to build our homes, therefore, women have no right to limit their births. (Young man, Ketiu)

> When you marry her and she gives birth to one child, she will tell you she wants to do family planning and then can give birth again after three years. Because she wants to do what she likes, as soon as you give her the chance, she will go to the nurse and ask her to do things that you are not aware of. And so in the end, you will have only one child. But in this place, respect is accorded to people who have many children, so if you have only one child, and even if you are well-to-do, nobody will respect you with all your wealth. If the woman does that to you, what will you do? That is the reason why we don't talk family planning with our wives. (Male opinion leader, Naga)

A steady supply of children is viewed as essential in a society that depends on large, strong lineages by which male authority and respect are enhanced. Male focus-group participants mentioned their fear of child mortality and of infertility more frequently than did women. In the face of these threats, men emphasized the security of having many children, whereas women's discussions focused more on the importance of assuring the health of their offspring through prolonged spacing. Although women's reproductive strategies differ from those of men, they understand the expectations they are supposed to fulfill. As a young woman put it: "If we give birth till the time the man's mind wants, he will then tell you to stop, for you have given birth to the time he wants and you have paid for all the cows." (Naga village)

Women's Infidelity

Men also voice the concern that women who practice contraception are likely to be unfaithful to their husbands and abandon their families. Such anxiety reflects not only concern for the potential loss of a spouse but also for the ridicule that this circumstance would be likely to entail. Women's perceived promiscuity damages men's status, honor, and pride. Moreover, in a society

where women are "acquired" through payment of considerable resources, the possibility of losing a wife constitutes a major economic threat:

> Family planning makes women become flirts. Because they are practicing family planning, they know they will not get pregnant again, and they go after men outside their marriage. (Young man, Kayoro Akania)

> One bad thing about family planning is that, immediately after your wife adopts a method and now feels confident that she will not get pregnant again, she packs her things and leaves for either Kumasi, Accra, or Bolga, or even Cinkase, and starts flirting, leaving you and the children at home. (Young man, Naga)

> When you talk of family planning, the women even have people outside more than the men. She will tell the husband that she is doing family planning; meanwhile she does not even love him any more. And by the time you are aware, she is pregnant with someone else. So because of that, we are afraid. (Male opinion leader, Naga)

Women's interest in fertility regulation and how it produces gender-related tensions is described in a recent review of literature on contraceptive use in sub-Saharan Africa: "a woman who contemplates family limitation must face the possibility that any interruption in childbearing may signal, both to the husband and to the lineage, that she has effectively abandoned the marriage" (National Research Council 1993: 114). Reporting on a population living north of Navrongo in Burkina Faso, McGinn et al. (1989) found that men believe women will become unfaithful if they have access to contraceptives. Moreover, Bledsoe and Hanks's (1998) work conducted in the Gambia suggests that men's anxieties may arise from a difference in the reproductive strategies of men and women. A woman may wish to delay her next birth not only because she desires to protect her health and that of her children but also because she wants to keep her reproductive and conjugal options open**.** This could be true especially if she is dissatisfied with her marriage. When a woman tries to keep her reproductive capacity from being worn out too soon, her husband may think that "she must be saving [it] for someone else" (p. 16). This may be precisely what some women are doing.

Men's Loss of Control

A related anxiety-provoking issue for men is the sense of a loss of control when their wives decide to use contraceptives secretly or without consulting them. Male focus-group participants were overwhelmingly of the opinion that women have no right to make decisions by themselves, let alone make decisions about contraceptive use. Even men who accept the idea of contraceptive use insist that such decisions must be made with their knowledge and consent, because in a patriarchal society, men are the dominant decisionmakers.

> I know that there are various contraceptives that can be used to prevent a pregnancy, and each has its side effects. So if a woman comes to adopt a method without first informing her husband and later on develops a health problem, it worries the husband. But if the husband knows which method she is using, it helps a lot. (Young man, Naga)

> The contraceptives really help, and we are not against the use of these methods, but if a woman comes to the clinic without the husband, [you should] insist that she bring her husband. These women are trying to take control of our homes as decisionmakers. (Young man, Naga)

Other men take a stronger position:

> To limit their births, without our concern, without our permission, when they do it they will die. That is why many women die in the process and they think it is the fault of the doctors. (Young man, Ketiu)

> [No] matter who and how a woman is, her intellect is very small. A woman must use a method in the presence of the husband. That is the solution. (Old man, Kologo)

Women also agree that the critical issue is the husband's control, and that as long as their permission can be obtained, women are free to use contraceptives:

> When you go to adopt a method of family planning with the consent of your husband, you do not face problems, but if you go and use a method without his approval, immediately after you get home, you will be beaten seriously. (Old woman, Kologo)

However, if women choose to act on their own and find that they encounter problems with contraceptive use, they are likely to be blamed for damaging not only themselves, but also the corporate entity of the family:

> If the woman goes [to obtain a method] without informing the man and she gets a problem, they will say the woman has spoilt the house. (Young woman, Kologo)

On several occasions in the focus-group discussions, men almost pleaded with the moderator that the project insist that men be involved when women come to the clinic asking for contraceptives. They also make this point at traditional durbars, discussed below. By providing women who live in this traditional and gender-stratified society with the technology to facilitate control of reproduction, the Navrongo project potentially disturbs the existing social order. Contraception enables women to assert their individual preference above the interests of the group, to challenge male decisionmaking authority, and to slow the constant stream of births. In this context, that contraceptive use provokes anxiety is not surprising.

Program Responses

As the data from focus-group transcripts reveal, women's use of contraceptives threatens the system of gender relations in a society where men and women's power is markedly unequal. Women's social obligations to reproduce appear to be in jeopardy, as do male roles as decisionmakers. The greater the gender imbalance in a society, the more likely it is that the introduction of contraceptive technology and services will provoke anxieties and conflict. Because the control over women in Navrongo is still complete, and their status as property is so deeply rooted, the potential exists for women's independent action in regulating fertility to upset the existing social contract that defines gender relations (Antwi-Nsiah et al. 1995; Phillips et al. 1997b). In such an environment, attention to these relations must be part of the overall design of the family planning program. In addition to the integration of family planning with less controversial health services, three general strategies have been used in the Navrongo project: First, the project has mobilized participation and cooperation of chiefs, elders, and lineage heads, and also more recently, the active participation of women's groups and individual women. Second, the project has engaged in direct outreach to men by providing them with education, communication, and family planning services. Third, the program responds to women's need for direct support when problems arise.

Involving Local Leaders and Women's Groups

In the Navrongo Community Health and Family Planning Project, attention to gender relations has been an integral component of the effort to align the introduction of contraceptive technology and services with traditional social institutions. The active involvement of local leaders and groups (chiefs, village committees, community assembly members) in preparing for the Navrongo experiment provided early opportunities for confronting the potential for gender conflict and for explaining family planning within the context of traditional values. Paramount chiefs affirmed that they would "tell the men not to quarrel with their wives when they are practicing family planning" and willingly displayed condoms on the occasion of traditional *durbars*, public meetings through which Kassena-Nankana leaders communicate with the local people. Village committee members also explain to concerned men on these occasions that modern contraception helps people with their traditional interest in spacing births. Through this approach, the project aims to legitimize family planning, and to publicize the service program by means of the traditional male-dominated power structure.

Durbars are attended mainly by men and are convened by a paramount chief and his council of chiefs to discuss some matter of collective concern to communities, such as the need for communal labor or cooperation on a project. Durbars take place in an open area near the chief's compound, and are typically accompanied by drumming, dancing, and considerable pageantry. Various community leaders speak to an assembled crowd, and formal presentations are followed by informal questions, discussion, and answers that often can involve several hours of dialogue. The Navrongo Centre has made use of the durbar custom to inform communities about its health-research programs. Its participation builds collaboration with traditional leaders, establishes open discussion of health-related topics with the community, and legitimizes the Centre's community health activities. The Centre's participation in durbars is welcomed throughout Kassena-Nankana District.

Over time, the Navrongo project has sought to introduce changes in the durbar custom. First, it has focused the content of durbars on health and family planning themes. In recent months, a drama troupe has provided community education on health and family planning with "responsible manhood" figuring prominently in drama program themes. Second, the frequency of durbars has been accelerated to a 90-day cycle, so that events are regular celebrations of program progress and are designed to be informal, festive, and informative. Finally, participation has been broadened to include women. In 1994, community leaders were requested to invite women to attend durbars. Although this effort succeeded in some instances, organizing women's durbar participation often failed. To foster group participation, the project undertook a direct program of outreach to women's singing groups, church groups, market associations, and political networks. As the project has pro-

gressed, women's participation has increased. Women's groups attend durbars spontaneously, and women join in the durbar questions and dialogue in ways that would have been unthinkable in the initial months of project activity.

A 1999 durbar in Naga village illustrates this change in women's involvement. Whereas durbars were once entirely male dominated, the recent Naga durbars, responding to project initiatives, are heavily attended by women, many of whom participate as individuals. In the course of the durbar, a young woman spoke about her view that men are irresponsible in demanding many children when it is women who must bear the burden of childbearing. Public translation of durbar exchanges was conducted by a man who was designated by the paramount chief for this role. In this instance, the community translator refused to translate the woman's comments. The women in the audience cheered her on, however, expressing enthusiastic approval for her open criticism of men. Women's perception of their role at such occasions has clearly changed in this particular village, and program strategies have been instrumental in producing this climate of greater openness.

Outreach to Men

After the project was launched, community nurses and volunteers began to address their family planning and health messages to women and also to men, while simultaneously assuring women that they would have the opportunity for secret contraceptive use. Field-workers including nurses and village volunteers approach men to explain the program, answer questions about health and family planning services, and treat minor illnesses. Occasionally, sessions are organized for groups of men to emphasize the communications goals of the program and to encourage open discussion of family planning among men.

Among the Kassem and Nankam, well-organized village-level associations meet regularly to undertake common projects and other activities to promote the general interest and welfare of the group or of the community. Male village associations, such as drumming and farming groups, are particularly common in most communities throughout Kassena-Nankana District. Members of these groups are usually organized for cooperative farm labor or other projects. These occasions provide useful opportunities for project staff, community nurses, or male village health volunteers to reach out to groups of men to discuss project activities with them. During the dry season, when farm work lessens, members of these groups sometimes meet in the evening at popular spots in the village to organize drumming and dancing. On these occasions, project staff often organize outreach activities in collaboration with resident nurses or village health volunteers.

During their home visits, project nurses and health volunteers often assemble groups of men and women to discuss health and family planning activities. Gradually, this frequent interaction with the community is beginning to legitimize and demystify family planning.

In the initial months of program operation, male outreach was separated from support for women. As men's understanding of the program has grown, however, women have been included in male outreach activities. Ultimately, this congenial atmosphere is intended to allay the fears and anxieties of women about their husbands' opposition to the practice of family planning.

Support for Women

When conflicts are reported by project staff, a major effort is made to protect women's interests and safety by assembling a team of male supervisors to visit the household, call community attention to the man's behavior, and persuade him to end the conflict. For example, early in the Navrongo experiment, a woman received an injectable contraceptive from a community health nurse who, substituting for a colleague, was unaware of the woman's husband's earlier request that family planning not be discussed with his wife. When the woman experienced amenorrhea, her husband believed her to be pregnant. He became intensely suspicious when he learned that she was not. He locked her in a room, threatened her with a knife, and beat her. When the woman confessed that she had used the injectable, he threatened to kill the nurse. Project staff immediately summoned supervisors, and a delegation was sent to the husband to explain the situation, calm him, and establish that project support existed for women.

In another case reported by a community volunteer, a man became suspicious that his wife was using a contraceptive when she failed to become pregnant. Because she denied use, he searched her belongings and discovered oral contraceptives. Instead of confronting his wife directly, the man pretended that the soothsayer had told him that she was using oral contraceptives. When the wife continued to deny use, he destroyed the pills and threatened her. She alerted the community nurse to her problem; the nurse then spoke to the man and calmed him.

Efforts to reach out to chiefs and other leaders have generated village dialogue leading to subtle and sustained improvements in the gender impact of the project. Sustaining the mobilization activities of community health nurses and their supervisors has proved to be more difficult, however. In a 1999 discussion session of

community health nurses, an episode of wife beating was raised. A nurse had been approached by an angry man and he had asked her to confirm that she recognized his wife in a photograph. When the nurse did so, the man returned home and beat his wife, assuming that recognition was tantamount to confirmation that his wife was using contraceptives. According to project rules, this episode should have been communicated immediately to project supervisors so that the man could have been approached. Because the nurse was new to the district, however, and had not been instructed about appropriate responses to such problems, no action was taken. In fact, new staff were not familiar with the gender-impact agenda of the project, and existing supervisory staff had neglected its implementation. Experience indicates, therefore, that a successful and responsive agenda of this sort requires sustained attention, worker training, and frequent meetings with service-delivery staff.

Conclusions

The themes discussed in this report are derived from 36 focus-group sessions with Kassena-Nankana men and women assembled to assess community reactions to the Navrongo experiment, not to investigate tensions in gender relations resulting from the introduction of contraceptive methods and services. Some of the discussions were relatively short, others lengthy. Because these discussions were convened in a society exposed to new ideas and experiencing the early stages of contraceptive adoption, the present analysis should invite further research specifically directed to these themes. The authors wish to emphasize that each of the examples and subthemes presented here were not the principal preoccupation of all the interviews, but that the overall theme of gender-related tensions was widely and consistently expressed in the lengthier sessions and often discussed in a milder way in the shorter sessions.

Gender tensions expressed in these sessions are grounded in complex customs governing marriage, family building, and spousal relations that have evolved to perpetuate lineages, promote fertility, and protect the extended household. Family planning programs often develop promotional campaigns and community distribution systems that fail to address the gender tensions that such services generate. Failure of this nature can lead to social discord, threats, and even violence. Although the Navrongo project has made extensive efforts to anchor the introduction of family planning services to the existing social and cultural institutions and to protect women who are exposed to violence resulting from their use of contraceptives, further research is warranted to clarify the mechanisms through which women's interests can be more broadly supported.

Experience shows that innovations depending solely on the activities of Ministry of Health staff are more difficult to sustain than are those using traditional social institutions. Bureaucracies' resources are constrained. Ministry staff are detached from communities, and services lack social grounding. By contrast, building gender-sensitive approaches to family planning within traditional social institutions fosters sustainable communication, social interaction, and behavioral change that cannot otherwise occur.

The Navrongo project's approaches have focused primarily on marshalling existing male-dominated social institutions for health and family planning promotion, while simultaneously developing women's autonomy so that they may participate and pursue their personal preferences. The success of this approach is evident in the content of women's growing participation in durbars. However, these efforts remain limited, and negative male reactions to women's playing a role in this traditional social institution may yet arise.

The Navrongo program is a preliminary step toward a more sustained and broader-based approach for developing outreach to women. Prospects for fostering women's autonomy may be enhanced through outreach to market networks, lending societies, church groups, political associations, and other social networks. Although such a general strategy merits investigation, the Navrongo experiment has clearly achieved important gains for the women it serves. Agencies that provide health care and family planning services should direct resources to activities that address and resolve gender tensions that can and may arise from the services that they promote.

Notes

1 The view that family planning programs have had an impact on fertility is documented in the Programme of Action of the International Conference on Population and Development, Cairo (ICPD, 1996). Although this consensus is sometimes challenged on methodological grounds (for example, in Pritchett 1994), the position of the statement on the demographic role of programs has become the predominant view in the population field (see, for example, Bongaarts et al. 1990; Mauldin and Ross 1991; Freedman 1987; and Simmons and Young 1996).

2 Gender relations among the Kassena-Nankana are discussed in Adongo et al. (1997).

3 This article does not address the many positive effects that have been generated by the project. Although gender strategies are essential to developing community-based family planning services that are sensitive to women's needs, gender-service strategies

alone are insufficient for addressing underlying constraints on the roles and status of women implicit in patriarchal social systems. The long-term goal of developing women's autonomy and status in the Navrongo project is being addressed through initiatives designed to foster women's group participation and identity, their political participation, and their economic autonomy. These general gender-related development components of the Navrongo experiment are not discussed here.

4 Economic development in Africa has often been associated with unanticipated detrimental consequences for women. Economic or social gain for women in patriarchal societies can lead to animosity and violence if the anxieties and concerns of men are not addressed. (See, for example, Bank's 1994 discussion of the causes of riots in South Africa in the 1980s.)

5 How child-related costs and benefits differ for men and women is discussed in Fapohunda and Todaro (1988).

6 The social acceptability of violence in this locality is not atypical of sub-Saharan Africa. See, for example, Blanc et al. (1996).

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