

MAKING MODERN FAMILIES

MAKING MODERN FAMILIES: FAMILY SIZE AND FAMILY PLANNING
IN NORTHERN GHANA

By LAUREN WALLACE, B.A.S.

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Dedication

This thesis is dedicated to the people of Kassena-Nankana West. Thank-you for your time and generosity. I look forward to visiting with you again.

A kele paaaa

Thank-you very much

Abstract

This thesis draws on a political economy of fertility framework and the concept of biocitizenship to analyze changing family size and family planning among women and men in northern Ghana. I draw on a variety of ethnographic sources from eight months of fieldwork conducted under the umbrella of the Navrongo Health Research Centre in 2013 and 2014 in two rural communities in Kassena-Nanakana (K-N) West District in the Upper East region. The primary questions behind this thesis are: 1. How has the desire for smaller families emerged and to what is this transformation linked? 2. What role have family planning programs played in the reduction in family size? Have they been the most important driver of the transition to smaller families? 3. What are the current ideas about family planning and contraceptives in K-N West? Are they gendered? How have they changed over time? 4. Are local views about family planning and contraceptives in K-N West in keeping with those of public health practitioners? These questions are addressed in this sandwich thesis in three papers, which have been submitted or accepted for publication.

A major contribution of this thesis is its call for health programmes to pay greater attention to the social context of both women's and men's lives where family planning takes place. Contrary to existing public health studies, I argue that while health programming has affected fertility decline, larger social and economic shifts have been some of the most

important drivers of women's and men's changing practices of family formation and views of contraceptives. In Kassena-Nakana West, the desire for smaller families is linked to processes such as decreasing levels of child mortality and agricultural productivity, as well as parents' increasing focus on educating their children. In addition, the emerging concepts of responsible manhood and companionate marriage, combined with the decline of polygamy, have helped improve communication between husbands and wives about family planning.

Narratives of changing family formation from Kassena-Nankana West expand understandings of biocitizenship by illustrating the important role intergenerational relationships play in the construction of "political economies of hope". When young people adopt family planning, they not only consider the well-being of their own children and the larger community, but make the decision in the context of their aspirations for a more successful life than their parents experienced.

Due to larger political-economic shifts, the majority of Kassena women and men today think family planning is beneficial; however, worries about the side effects of contraceptives remain. Women's ongoing concerns about infertility and the stability of their marriages and men's conditional acceptance of family planning also reveal that gender inequality persists. I argue that typical policy recommendations, which focus primarily on educating and sensitizing communities to increase the

use of contraceptives are problematic in that they often focus on decreasing fertility and are not articulated within a broader, multi-sectoral agenda. Greater attention to local biologies and expanding reproductive rights and freedoms would improve existing family planning programs.

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Table of Contents

Title Page	i
Descriptive Notes	ii
Dedication	iii
Abstract	iv
Acknowledgements	vii
Table of Contents	x
List of Figures	xiii
List of Abbreviations	xiv
Statement of Academic Achievement	xv
Chapter 1: Introduction	16
Demography and Fertility	22
The Malthusian Myth	22
Theorizing Fertility Decline	24
A Political Economy of Fertility	28
Thesis Format	32
Chapter 2: Study Site and Methods	37
Kassena-Nankana West	41
The Kassena	43
Histories of Migration and Change	44
Wealth and Well-Being in the north	48
Economic Life	53
The Environment	55
Social and Political Organization	59
Health System Structure	63
Marriage and Family-Building	64
Value of Children	66
Methods	69
Language Training	71
Entering Kalivio	74
Consulting Community Leaders	74
Genealogies	76
Participant Observation	77
Focus Groups	79
Interviews	81
Expert Knowledge	83
Health Workers	84
Field Notes and Data Analysis	85
Knowledge Translation	89

Chapter 3: Change and Continuity in Kassena Men’s Perceptions of Family Planning in Northern Ghana	89
Abstract	89
Introduction	90
Family Planning in Ghana	94
Study Site	98
Methods	99
Results	101
Social and Economic Benefits of Small Families	104
Changes in Perceptions of Family Planning and Marital Relationships	109
Discussion and Conclusions	114
References Cited	120
Chapter 4: Making Modern Families: Family Planning and Biocitizenship Among the Kassena of Northern Ghana	125
Abstract	125
Introduction	129
Family Planning in Ghana	129
Study Site and Methods	130
Modernizing the Kassena Family	133
Fertility Deviants	137
Gender, Age and Family Planning	140
Health Workers’ Views	145
Discussion and Conclusions	146
References	151
Chapter 5: “It Doesn’t Match my Blood”: Concerns about Contraceptive Side Effects Among Kassena Women in Northern Ghana	156
Abstract	156
Family Planning in Ghana	158
Family Planning in sub-Saharan Africa	159
Kassena-Nankana West District	164
Infertility and Fertility Control	165
The Gendered Nature and Social Costs of Fertility Control	167
The Perceived Dangers of Contraceptive Use	169
“It Doesn’t Match My Blood”	172
Conclusion	174
Bibliography	177

Chapter 6: Discussion and Conclusions	180
Question 1	182
Question 2	188
Question 3	191
Question 4	195
Conclusions and Recommendations	198
Future Directions	205
References	208
Appendices	223
Appendix A	223
Appendix B	226
Appendix C	227
Appendix D	229
Appendix E	231
Appendix F	232
Appendix G	233
Appendix H	234
Appendix I	235
Appendix J	236
Appendix K	238

List of Figures

Chapter 2: Study Site and Methods

Figure 1: Vendors sell their wares on market day in Navrongo	38
Figure 2: An office block at the Navrongo Health Research Centre	40
Figure 3: Map of Kassena-Nankana West and Kassena-Nankana East Districts	42
Figure 4: The Basilica in Navrongo overflows with worshippers on a Sunday	49
Figure 5: Young men weed groundnuts	57
Figure 6: A grandmother works to build a new room in her brother-in-law's compound in the dry season	58
Figure 7: Compound with a mix of laterite (mud) and cement block rooms in K-N West	60
Figure 8. Home in Haatso, Accra	61
Figure 9: Women's homes in the Gambaga witch camp	68
Figure 10: Carrying a "light" load of firewood for the first time	77
Figure 11: A young father's drawing of his ideal family	82
Figure 12: Study results are disseminated at a durabar in K-N West	86

Chapter 5: Making Modern Families: Family Planning and Biocitizenship among the Kassena of Northern Ghana

Figure 1: Front Cover of the Life Choices Flip Chart	146
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List of Abbreviations

BCS	Behaviour Change Support
CHFPP	Community Health and Family Planning Project
CHPS	Community-Based Health Planning Services
CHO	Community Health Officer
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
IUD	Intrauterine Device
JSS	Junior Secondary School
K-N	Kassena-Nankana
MOH	Ministry of Health
NHRC	Navrongo Health Research Centre
PATH	Program for Appropriate Technology for Health
SS	Secondary School
TFR	Total Fertility Rate
UER	Upper East Region
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAST	Vitamin A Supplementation Trial
WHO	World Health Organization

Statement of Academic Achievement

I am the main contributor to the three articles presented in this thesis.

Chapter 3 “Change and continuity in perceptions of family planning among the Kassena of northern Ghana” is a co-authored paper with Dr. Philip Adongo submitted to *Human Organization* in August 2016. I am the first author. I conducted the follow up ethnographic fieldwork for this paper in 2013/2014 and analyzed the data. I wrote the first draft and collaborated with my co-author, Dr. Philip Adongo on the revisions to the manuscript.

Chapter 4 “Making modern families: Family planning and biocitizenship in northern Ghana” is a single-authored paper submitted in February 2015 to *Controlling Sexuality and Reproduction: Then and Now*, edited by Claudia Malacrida and Danielle Peers (University of Toronto Press). This paper has undergone peer review and has been revised and resubmitted.

Chapter 5, “‘It doesn’t match my blood’: Concerns about contraceptive side effects among Kassena women in northern Ghana” is a single-authored paper that has been accepted for *Gender and Feminism in the 20th Century and Beyond*, edited by Glenda Tibe Bonifacio (Springer). I collected the data for Chapters 4 and 5 in 2013 and 2014, analyzed the data and wrote the manuscripts.

Chapter 1: Introduction

In the Upper East Region of Ghana, the bumpy, pot-holed filled road into Kalivio from Navrongo runs west through Chuchuliga, past Kanania and Nyangia. Travelling out of Navrongo town, the tide of vehicles and humans dissipates as the road leaves town and heads further west. Once through Chuchuliga, the paved section of the road drops off and the landscape opens up into a vast space of compounds surrounded by farm fields. Close to the road lives 55-year old Millicent¹, her husband Thomas, and her family. Millicent has six living children, one boy and five girls. Four children died at the young ages of one and two from malnutrition, measles and malaria. Three of the children died one after the other. Millicent has no source of income except from farming and petty trading. She and her husband never attended school.

Only one of their grown children, Abraham, finished school. Since his parents never had the money necessary for schooling, Abraham, now University-educated and working in town, had to fund his Secondary School fees and University education. The only children who will get a job in the next two to three years are Abraham and his senior sister. The eldest child, Veronica, lives a thirty-minute drive from Kalivio aboenia, has only been to primary school, and is unemployed. Her husband died a few years ago, leaving Veronica and her four children without income.

¹ Pseudonyms are used to protect the identities of my interlocutors.

Speaking about his wishes for his future family, Abraham said he only wants three children so that they can be educated and get the best in life.

Most of the residents who live in Kalivio aboenia and awenia, part of Kassena-Nankana West District, are farmers. Unarable land, and lack of employment encourage young people to travel to Navrongo or to cities further south to find work. Sanitation and nutrition have been a serious concern since the 1980s (Howell, 1982). Even though health research completed in this community and in surrounding areas confirms that fertility and child mortality has declined, and that there is a desire for smaller families (Dalaba et al., 2016), citizens remain poor.

In Ghana, the fertility rate is 4.2 (GHS & GSS, 2015). This rate is one of the lowest in sub-Saharan Africa, a region that has been characterized as more resistant to fertility decline and family planning than all other regions of the world (Caldwell & Caldwell, 1987; Bongaarts & Casterline, 2012). Ghana's drop in fertility is regarded as a success story by demographers (Agyei-Mensah, 2006). In 1967, the Government of Ghana was the first country in sub-Saharan Africa to sign the World Leaders' Declaration on Population and a National Family Planning program was introduced in the 1970s (Caldwell & Sai, 2007). However, despite this longstanding attention to family planning, it was not until 1993 that Ghana announced that the transition to lower fertility had finally begun. Data from the 1993 Demographic and Health Survey detected a

decline from 6.4 children per woman in the late 1980s to 5.5 in the early 1990s (GHS & GSS, 2009). With a Total Fertility Rate (TFR) of 4.0 in 2008, Ghana achieved its fertility target two years before the target year (2010). The downward trend in fertility is supported by married women's increasing use of contraception, which rose from 13% to 23% between 1988 and 2008 (GHS & GSS, 1989; GHS & GSS, 2009).

K-N West and K-N East are particularly ideal locations from which to examine shifts in family formation and family planning in Ghana. They form part of the Sahelian region of sub-Saharan Africa, which has long been characterized as a setting that has maintained high fertility and resisted family planning. The Sahel is a semiarid region of western and north-central Africa which extends from Senegal eastward into the Sudan. The region is characterized by extreme climate variations, posing a barrier to poverty reduction and food security (Essoungou, 2013). In the 1990s, fertility rates in the Sahel were double the levels elsewhere in the developing world, and rates of contraceptive prevalence were the lowest of any region worldwide (Van de Walle & Foster, 1990).

Demographers have argued that traditional social institutions act to sustain high fertility and make the Sahel particularly challenging for family planning programs (Phillips et al., 2012; Caldwell & Caldwell, 1987). Customs such as bridewealth and polygamy led to the perception of women as property purchased for the production of children. Lineage-

based kinship and religious systems, upward wealth flows and high child mortality rates meant that fertility regulation was focused on spacing children, rather than limiting family size (Adongo et al., 1997; Caldwell & Caldwell, 1987). Beyond the fact that people were characterised as living in “a climate of traditionalism”, demographers described the way in which the remote geographic location of northern Ghana also constrains the provision of primary health care and family planning services, and how the dispersed pattern of settlement, combined with a low level of literacy “effectively isolates [individuals] from new ideas and institutions” (Nazzar, Adongo, Binka, Phillips & Debpuur, 1995, p. 310). In 1988, an average of 6.6 children were born to a married woman in her lifetime, and few married women in Kassena-Nankana District used any form of contraception. Influenced by observers such as John Caldwell (1987), demographers argued that the prospects for fertility control remained challenging (Adongo et al., 1997).

In response to the challenges of high fertility, in 1994 the Navrongo Health Research Centre launched the Navrongo Community Health and Family Planning Project (CHFPP), also known as the Navrongo Project. This quasi-experiment, which involved populations living in K-N East and West, was tasked with assessing the impact of various “treatment” designs of primary health and family planning services on fertility and mortality rates. The experiment aimed to reduce the social costs of contraception

and to test the hypothesis that “family planning service delivery can induce and sustain reproductive change in a traditional rural African population” (Binka, Nazzar & Phillips, 1995, p. 124). The most successful strategy involved a combination of training community health nurses to live and work in village locations, assigning community health workers to provide basic curative and preventative health services, and engaging traditional cultural institutions and social organization to reduce the social costs of contraception. This included mobilizing chiefs and addressing male opposition to increase women’s participation in family planning services (Phillips et al., 2012).

Between 1998 and 2008, the TFR in the region declined from 4.9 to 4.1, while contraceptive use increased from 9% to 14.7% (GHS & GSS, 1999; GHS & GSS, 2009). Evaluation of the impact of the Navrongo project was complicated by the fact that fertility was declining throughout Ghana in the 1990s. Nevertheless, fertility decline was attributed in part to the successful program, which reduced fertility and child mortality rates and showed that “supply side strategies [to family planning] can have an impact despite profound cultural, economic and social constraints to success” (Phillips et al., 2012, p. 187). While research to date has considered the influence of primary healthcare and family planning programs on declining family size and increasing contraceptive use

(Dalaba et al., 2016), it has not adequately captured the influence of changes in the socio-cultural context on fertility.

As a case study framed by the political economy of fertility (PEF) (Greenhalgh, 1990), the ethnographic account presented in this thesis explores how residents of K-N West understand family planning and fertility decline. I draw attention to the social and cultural context of changes in family size; in doing so, I critique public health accounts of fertility transition and family planning practice and make recommendations to improve family planning programs.

The following questions guided my research:

1. How has the desire for smaller families emerged in K-N West and to what is this transformation linked?
2. What role have family planning programs played in the reduction in family size? Have they been the most important driver of the transition?
3. What are the current ideas about family planning and contraceptives in K-N West? Are they gendered? How have they changed over time?
4. Are the locally-held views about family planning and contraceptives in K-N West in keeping with those of public health practitioners?

This thesis draws on three related areas of anthropological study: the challenging synergy between demography and anthropology, the anthropology of reproduction, and the anthropology of development, especially as it relates to the promotion of technical solutions that neglect larger gendered social and political issues.

Demography and Fertility

The Malthusian myth. The first large scale demographic surveys used globally were the Knowledge, Attitude and Behaviour surveys and the World Fertility surveys, driven by concerns about the impact of high fertility on development (Presser, 1997). However, demographers have been concerned about balancing a growing world population against decreasing natural resources ever since Thomas Malthus, British clergyman turned economist, published his *Essay on the Principle of Population* in 1778 (Malthus, 1926). Malthus maintained that unless human populations were controlled by “preventative checks”, they would grow exponentially, doubling every 25 years. Using elementary arithmetic, he predicted that population growth would outstrip the earth’s carrying capacity – the number of people that the earth can support without starvation or environmental degradation. According to Malthus, only forces of misery such as poverty, famine and war would keep populations in check.

Scholars have concluded that Malthus was wrong to make generalizations about the carrying capacity of the earth; it is difficult to estimate the impact of population growth since it differs from one setting to another and is affected by myriad social and economic issues (Hartmann, 1995). One of the largest problems with Malthus’s theory is the neglect of social, political and economic power and their impact on the unequal

distribution of resources. As Hartmann points out, issues such as food crises in sub-Saharan Africa, have more to do with power imbalances and low productivity than population size per se. Histories of colonialism led resources to be concentrated on growing cash crops for export. In recent years, foreign aid programs have often favoured foreign technologies rather than indigenous knowledge and labour (Hartmann, 1995).

However, the complexities of population change and its relationship with resources and development have continued to be ignored by the public and by some health and development professionals. Proponents of population control and family planning today have selectively applied neo-Malthusian logic to developing countries, where higher birth rates and lower living standards coexist with low levels of economic development. Stanford biologist Paul Ehrlich has probably commanded the widest public audience in utilizing neo-Malthusian logic to spread the myth of overpopulation and reinforce the need for population control in the so-called "Third World". In his famous book, *the Population Bomb*, Ehrlich (1971) drew on visions of overwhelming crowds of the dark-skinned poor to advocate for the need to prevent the world from breeding itself into oblivion. He opens his discussion with a story from a family trip to India, where he found the number of people in the streets frightening:

I have understood the population explosion intellectually for a long time. I came to understand it emotionally one stinking hot night in Delhi a few years ago. My wife and daughter and I were returning to

our hotel in an ancient taxi...As we crawled through the city, we entered a crowded slum area. The temperature was well over 100 and the air was a haze of dust and smoke. The streets seemed alive with people. People eating, people washing, people sleeping. People visiting, arguing and screaming. People thrusting their hands through the taxi window, begging. People defecating and urinating. People clinging to buses. People herding animals. People, people, people...the dust, noise, heat, and cooking fires gave the scene a hellish aspect. All three of us were frankly, frightened (Ehrlich, 1971, p. 1).

Quoting Kingsley Davis in *Science*, Ehrlich argues that rather than “stressing the right of parents to have the number of children they want” societies must have only the “number of children they need” and promoted strict measures for achieving this goal, including compulsion (Davis, 1967, p. 158; Ehrlich, 1971, p. 79). Although family planning rhetoric has shifted from population control to expanding reproductive rights (ICPD, 1994), important development organizations such as UNFPA (2014) continue to expend large amounts of resources promoting family planning on the basis that high fertility is responsible for the mismatch between resources and population.

Theorizing fertility decline. To predict population change, demographers have relied upon classic demographic transition theory. This theory describes the growth of the world population as determined by two factors – fertility and mortality rates. Essentially, the argument states that “traditional” societies progress from a pre-modern state of high fertility, high mortality and irrationality to a “modern”, rational state in which fertility

and mortality rates are low and population growth has stabilized (Davis, 1945; Notostein, 1945).

Patterns of fertility decline that deviated from the model in regions of the world, such as sub-Saharan Africa (Bongaarts & Casterline, 2012), pointed to the poor utility of the theory. Countries like Ghana remained in the early stages of the transition in the 1970s and 1980s, despite the existence of family planning programs (Agyei-Mensah, 2006).

Anthropologists have been critical of the European context in which the theory is based and note it is unlikely to be a good template for all countries (Greenhalgh, 1995; Bradley, 1997). As Bradley shows in her discussion of fertility decline in Kenya, modernization theory does not take into account the ways in which the demographic transition may lead people “at the edges of the world economy” to lose ground in the face of development (Bradley, 1997, p. 247).

Demographers have proposed various explanations for fertility patterns that deviate from the predictions of the model. Two of the most popular theories draw on economic, social and political processes. Caldwell’s ‘Wealth Flows’ theory suggests that the transition between high and low fertility societies depends on changes in wealth flows, which are “labor and services, goods and money and present and future guarantees” (Caldwell, 1982, p. 459). Reversals in wealth flows occur due to the shift from an emphasis on a kin-based system in which power is transmitted

along gerontocratic lines, to a focus on market economics and mass education. Later, Caldwell (1997) proposed a new approach which he termed “global fertility transition”. In contrast to his earlier discussion, he argued that social interactions at the personal and community level are less important than global legitimation of family planning and the assistance of global actors and interactions in providing assistance with access to contraceptives.

Soon after Caldwell published his model, Bongaarts and Watkins (1996) proposed the diffusion approach to fertility decline, which remains one of the most popular explanations for fertility decline today. Bongaarts and Watkins argue that pre-transitional populations are not familiar with birth control and that the adoption of contraception occurs through “ideational change” in which ideas and information about contraception and family planning are spread through social interaction or mass media (Casterline, 2001, p.11,13). This approach for understanding fertility change is appealing to donor agencies and national governments, since it emphasizes the ability to bring about fertility decline via population and family planning programs but without requiring broader improvements in development indicators.

The link between fertility and the position of women is built into both classic and post-classic theories of fertility decline. Increased educational opportunities (Caldwell, 1982), economic opportunities (Handwerker,

1989), or knowledge about and access to contraceptives (Bongaarts & Watkins, 1996; Caldwell, 1997) are hypothesized to increase women's use of contraceptives and therefore lead to fertility declines. Post-classic fertility transition theories move beyond classic demographic transition theory to consider more nuanced social and political processes. However, these models remain indebted to the concept of a single unifying theory of fertility transition. They also dismiss the realities of power imbalances and underdevelopment that dominate the histories of the world's poorest countries, neglecting to take into consideration the existence of structural adjustment policies and other forces that disrupt narratives of equality and opportunity between actors.

Finally, these explanations rely on outdated concepts of women's status (Watkins, 1993). While descriptions of women's roles in anthropology and other social sciences use the construct of gender to formulate theories about reproduction, demographers have drawn on outdated concepts of private and public spheres of activities (Greenhalgh, 1995). In creating these roles for women, demographers assume that fertility decline is accompanied by opportunities for empowerment such as work outside the home (Watkins, 1993; Bradley, 1995). The overt focus on women's concerns and activities also masks men's and other actors' perspectives and their significant involvement in decision-making about family size and contraceptive use. In particular, existing accounts of men's

roles in reproductive health tend to portray them as barriers. Scholars, however, are beginning to counter the normative concept in health policy of the oppressive or disinterested man (Barker, Ricardo, Nascimento, Olukoya & Santos, 2010:540). In arguing for a more nuanced perspective of population trends, McNicoll (1980) proposed the “institutional determinants” theory, which has been celebrated by anthropologists for its comprehensiveness. McNicoll situates microlevel patterns of reproductive change in terms of the larger institutional endowments of each society, such as political and administrative institutions, community structures, family systems and sex roles. McNicoll’s (1980) approach draws on locally-specific social and historical processes; however his consideration of power and membership in these institutions fails to provide attention to the role of individual actors’ power, agency and resistance.

A Political Economy of Fertility (PEF)

A significant contribution to understanding population change was made by medical anthropologists through their attention to political economy. While early reproductive anthropology studies focused on beliefs about fertility, following the publication of Paul Erlich’s (1971) book *The Population Bomb*, anthropologists increasingly showed that shifts in the social and political contexts in which reproductive decisions are made are central to reproductive health and rights (Mamdani, 1972; Hirsh, 2003;

Maternowska, 2006). Attention to the influence of national and international forces on local communities, termed the “politics of reproduction” (Ginsberg & Rapp, 1991), made power and politics and the “body politic” (Scheper-Hughes & Lock, 1987) central to anthropological understandings of fertility.

Building on earlier feminist and institutional critiques of demography’s static understanding of family-making, Greenhalgh was one of the first to apply the political economy framework (PEF) to studies of reproduction (Greenhalgh 1990; Greenhalgh, 1994). Greenhalgh developed a new framework anchored in anthropology’s holistic approach, which focuses on contextualizing the study of fertility within a larger analysis of the impact of history, economics, power, gender and culture. A political economy of fertility considers dynamic forces at both the micro and macro levels (Greenhalgh, 1990). This approach is closely linked with critical medical anthropology. As discussed by Singer and Baer, two proponents of critical medical anthropology, a political economic approach “emphasizes the importance of political and economic forces, including the exercise of power in shaping health, disease, and illness experiences and health care” (1995, p. 5).

A political economy of fertility framework has allowed anthropologists to engage more directly with demographers and demographic theory. Mobilizing political economic perspectives,

anthropologists have begun to push strongly for the integration of cultural anthropology and demography. Two edited volumes, *Situating Fertility* (Greenhalgh, 1995), and *Anthropological Demography* (Kertzer & Fricke, 1997) present research that places demography within anthropological theory and practice. Focusing on what anthropology's contribution might be to the study of demography, Greenhalgh's volume discusses the contributions of four aspects of anthropological theory to reproductive dynamics important for demographers: gender, power, history and culture (Greenhalgh, 1995). She argues strongly for a political economy framework and the construction of "whole demographies", which involves threading these four aspects into studies of reproduction (Greenhalgh, 1990; Greenhalgh, 1995). Kertzer and Fricke's (1997) volume, on the other hand, focuses more on the convergence and importance of culture, history, and power in both demography and cultural anthropology.

Several anthropological studies have applied the political economy approach to fertility behavior (Schneider & Schneider, 1995; Ali, 2002; Maternowska, 2006). Despite the utility of the PEF framework, studies of local-level communities often fail to take into account the totality of processes involved in family formation. Maternowska's (2006) *Reproducing Inequities: Poverty and the Politics of Population in Haiti* stands out as an exemplary application of a political economy framework. Maternowska asked why international agencies' family planning programs

failed in a desperately poor, urban community in Cité Soleil, Haiti. Her analysis, which considers both men's and women's lives, reveals that the program itself had become a repressive institution forced upon residents, mirroring local power structures used to control and silence the poor.

Maternowska argues that low contraceptive use extends beyond issues of compliance or quality of care. Family planning programs must be viewed as a politically-charged setting in which power relationships and underdevelopment shape the provision and perceptions of health care (Maternowska, 2006). Not only does she successfully integrate international recommendations to show how they shape family planning programs in Haiti, but she also uses an applied approach to make recommendations for program improvement, a rarity in anthropological studies using PEF.

Another relevant anthropological work is Ali's (2002) investigation of family planning in Egypt. Considering the impact of globally-created and nationally endorsed family planning policies, Ali mobilizes his discussions with husbands and wives to make the case that family planning programs construct a new kind of individuality linked to good citizenship. Like Maternowska (2006), Ali (2002) demonstrates the paradox of family planning policies and rhetoric in which ideas of choice and equity are promoted but simultaneously have negative effects.

Although anthropological research on family planning policies illuminates the relationships between men's and women's perspectives on family size and family planning and ideas of progress, poverty, and allegiance to the state, it has rarely considered how these discourses are shaped by intergenerational relationships. Changes in family planning policy and family size inevitably occur across generations and involve shifts in ideals about family formation. In this thesis, I examine family size and family planning in Ghana and use a PEF framework to explore the ways in which poverty, gendered discourse, the impact of intergenerational relationships, and social history shape changes in reproductive discourse and practice.

Thesis Format

This is a “sandwich” thesis comprised of six chapters of which three are standalone papers prepared for publication (Chapters 3-5). To orient the reader and provide more details of the research project, Chapter 2 situates family size and family planning among the Kassena within the broader socioeconomic, and historical context of Kassena-Nankana West. I also describe how I conducted ethnographic field research, analysed the findings, and disseminated the results of my research.

The paper presented in Chapter 3, *Change and continuity in perceptions of family planning among the Kassena of northern Ghana*,

was co-authored with Dr. Philip Adongo and submitted to *Human Organization* in August, 2016. It is currently under review. The paper was inspired by the work of Dr. Adongo and colleagues (1997) who investigated the gendered sociocultural processes that made women and men reluctant to limit family size and adopt contraceptives. Their study became the baseline for the Community Health and Family Planning Project (CHFPP) implemented in 1994. In the article presented in Chapter 3, we examine how men's perceptions of family size and contraceptives have shifted since Adongo and colleagues' original investigation. While the CHFPP itself contributed to changing ideas about family size and contraceptives, family planning has become more acceptable owing to larger socioeconomic processes that include declining levels of child mortality, reduced agricultural yields, and an increasing focus on children's education. We offer several suggestions to improve programs involving men. To our knowledge, this follow-up study is one of the first longitudinal, qualitative analyses of men's perceptions of family planning. I wrote the first draft of the paper, and Dr. Adongo assisted in revising the paper.

Chapter 4, *Making modern families: Family planning and biocitizenship in northern Ghana*, is a single-authored paper submitted for publication in *Controlling Sexuality and Reproduction, Then and Now*, edited by Claudia Malacrida and Danielle Peers (University of Toronto Press). This paper builds on the discussion in Chapter 3 pertaining to the

broader social and economic processes involved in shifts in family planning in Kassena-Nankana West; it has undergone peer review and been revised and resubmitted. Using the concept of biocitizenship, I explore how “reproductive rights and wrongs” (Hartmann, 1999) are deployed by citizens and health workers to demonstrate intergenerationally-patterned and gendered ideas about good parenting and family-making. I show how the rhetoric of government health programs, combined with a new “political economy of hope” (Rose & Novas, 2008, p. 452) linked to intergenerationally-patterned economic obligations, have contributed to positive views about family planning. To my knowledge, this is one of the first explorations of the links between intergenerational relationships and ideas about biocitizenship.

While Chapters 3 and 4 examine the broader processes that have had an impact on family formation practices, *It doesn't match my blood*: *Concerns about contraceptive side effects among Kassena women in northern Ghana* (Chapter 5), focuses more specifically on the side effects of contraceptives and women's experiences of family planning. It has been accepted for publication in *Gender and Feminism in the 21st Century and Beyond* edited by Glenda Tibe Bonifacio² (Springer). This paper picks up threads from my discussion in Chapter 3 on men's ongoing worries about

² The editor of this volume has agreed that I have prior rights to this chapter as it is part of my PhD thesis, and has not yet been published. Therefore no letter of permission is included.

the impact of contraceptives on women's health, future fertility, and on their lives. I argue that contraceptives have real social, physical and economic consequences that often go unaccounted for in demographic research. I explore women's ethnogynecological perceptions of the action of contraceptives on their bodies, particularly their understanding of the importance of "blood matching" for mitigating the side effects of contraceptives. I suggest that typical approaches to family planning programs sideline the need for a prudent agenda focused on ameliorating gender equity and make recommendations for policy in this regard.

In Chapter 6, Discussion and Conclusions, I address the contributions this thesis makes to larger discussions of family size and family planning within anthropology and in the demographic literature. This thesis research speaks to debates about the relationship between development, family size, and family planning programs. I contend that larger social and economic processes have been more decisive for fertility decline in Kassena-Nankana West than government-sponsored family planning programs alone. I suggest that the acceptance of family planning is embedded in a social process in which intergenerationally-patterned, idealized forms of parenthood and families are formed and linked to good citizenship. The Kassena conclude that smaller families are needed because of their worries about poverty, which upsets the demographic assumption that smaller family size necessarily results in equity. This

finding is yet another demonstration that family planning is not a panacea for development.

This thesis also points to the need for more intensive scrutiny of the social context in which contraceptives are used. Kassena women's useful ethnogynecological ideas about the importance of "blood matching" for contraceptives to be effective underlines anthropologists' observations that there are many ways to understand how the body works ("local biologies") and that family planning programs need to incorporate these views into their projects. Attention needs to be paid to the hidden costs of contraception borne by women, as well as to the shortsightedness of targeting fertility reduction to the exclusion of other significant concerns that permeate women's (and men's) lives, such as infertility, poverty and gender inequality.

I argue that nuanced, ethnographic research fills in gaps left by larger-scale demographic approaches to the study of fertility and family planning. A collaborative demographic anthropology that involves partnerships between anthropologists, demographers, and other stakeholders, such as public health professionals and local communities is essential to producing "whole demographics", which illuminate the relationships between culture and political economy (Greenhalgh, 1995, p. 9).

Chapter 2: Study Site and Methods

Walking into the town of Navrongo, my friend Ali and I soak up the sights and sounds. The shops are all open. Some are small stalls constructed out of wood and iron sheets, others made out of sturdier cement blocks or colourful shipping containers. The town is especially noisy this afternoon: horns honking, roosters crowing, music blaring and people greeting one another. The smells and sensations are familiar: dust, exhaust, garbage, smoke, heat, and sweat.

Usually, the atmosphere is fairly relaxed, however today, a market day and a Friday, the town is buzzing with excitement. The road is crowded with motorcycles, bicycles, and donkey carts, many carrying large loads of goods and people from surrounding villages and towns – Bolga, Paga, Chiana. Some have even travelled all the way from neighbouring Burkina Faso, which borders Navrongo from the north. Women walk with babies tied on their backs and huge burdens balanced on their heads. Children sit with their mothers, the younger ones playing in the dirt and the older ones helping to make change. Men sit at “drinking spots” to chat with their friends. Hungry dogs, pigs and goats rifle through the grass and gutters to find garbage and other sustenance. At first glance, population planners could easily form negative associations

between population and development in this setting. There are crowds of people, and everyone is trying to eke out a living.

Figure 1: Venders sell their wares on market day in Navrongo.

Photograph by L. Wallace, 2013.



I was glad to be back in Ghana. This time, I was no longer an undergraduate student. I had returned as a PhD Candidate examining family size and family planning, supported by a Vanier Scholarship from the Canadian Institutes of Health Research. My ethnographic fieldwork, conducted from July 2013 to April 2014 in two rural Kassena communities in Kassena-Nankana West district, was facilitated under the umbrella of

the Navrongo Health Research Centre (NHRC), building on connections I made in 2010 as a Unite for Sight Global Impact Fellow in northern Ghana. In 2010, I spent a six-week placement in northern Ghana learning from Ghanaian medical professionals as we worked to reduce barriers to eye care. In addition to a Certificate in Global Health and Program Delivery, I gained a deeper understanding of the problems facing patients in resource-poor settings. Through my work with Unite for Sight in Ghana, I was fortunate to meet Dr. Philip Adongo, medical anthropologist, Head of the Department of Social and Behavioural Science in the School of Public Health at the University of Ghana, and researcher at the NHRC. Dr. Adongo kindly agreed to support my thesis research and facilitated my introduction to staff at the NHRC, acting as a field supervisor.

As a major site for demographic and public health research in sub-Saharan Africa, the NHRC provided an ideal setting for my doctoral fieldwork. During my fieldwork, I lived at the research centre and travelled to my field site daily. Moving back and forth between the worlds of rural villages and the NHRC, located in Navrongo town, allowed me to develop an awareness of the activities of local and international public health researchers and make contacts with those who worked with the Ghana Health Service.

As a first step, I had sought out Aliyu Alhassan, my former research assistant and friend who walked with me through Navrongo during my first

trip to the Upper East in January 2013. Since my last trip to Ghana, Ali, originally from Tamale, had moved to Accra and had secured a coveted job at the Ministry of Agriculture, while his wife and three children remained in Tamale. In June 2013, Ali stayed with me in Navrongo until I could settle in and turn my attention to my research on contraceptive use and shifting family formation in Kalivio Aboenia and Kalivio Awenia in Kassena-Nankana West.

Figure 2: An office block at the Navrongo Health Research Centre.

Photograph by L. Wallace, 2014.

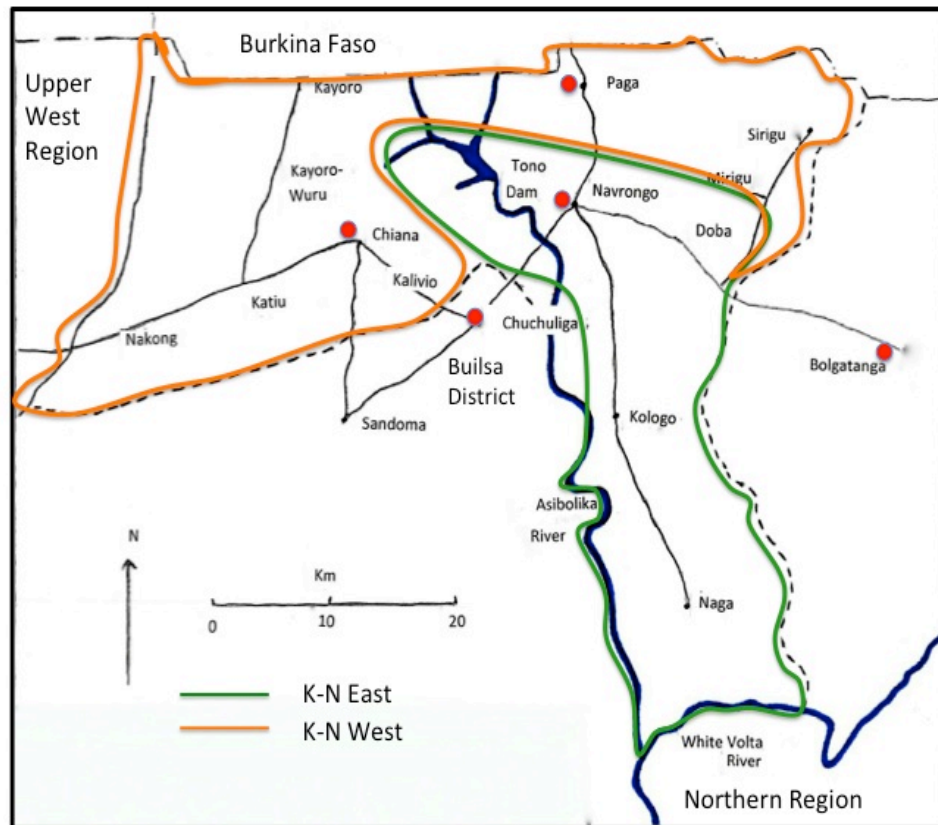


Kassena-Nankana West

Kassena-Nankana West (K-N West), together with Kassena-Nankana East (K-N East), are located in the Upper East Region, the second smallest and second poorest of ten administrative regions in Ghana. While the Ashanti, Eastern and Greater Accra regions to the South account for about 50 percent of Ghana's total population, the Upper East, to the north, is the least populated region, accounting for only 2 percent of Ghana's total population (GHS & GSS, 2015). Since 1993, the Navrongo Health Research Centre has operated a Health and Demographic Surveillance System (HDSS) in K-N West and K-N East to monitor demographic events, household composition and health status.

Fieldworkers routinely visit households every four months to update demographic data. According to the HDSS, together with K-N East, the region has a land area of 1,675 square kilometers. As of June 2011, the two districts had a population of 153,293 in 33,600 households (Oduro, et al., 2012). The two rural communities where I conducted this study, Kalivio Aboenia and Kalivio Awenia, had a population of approximately 1500 and 1200 people respectively at the time of the study. The villages are 20 kilometers from the closest major town, Navrongo, and are no more than 5 kilometers from Chiana, the closest major settlement, which contains amenities such as a health centre and small shops. Both communities are ethnically Kassena.

Figure 3: Map of Kassena-Nankana West and Kassena-Nankana East Districts. Drawn by Howell (1982) and modified by L. Wallace.



As sites with a rich history of demographic research on fertility, K-N West and K-N East are particularly interesting and relevant locations from which to examine local changes in family size and contraceptive practice. When I was planning my field research, I considered working in one Kassena community and one Nankana community for comparison purposes. Ultimately, several considerations prompted me to decide to centre my work in K-N West, a Kassena area of the district. First, my research assistant, Aurelia, was only fluent in Kasem. As an ethnographer,

I wanted to become deeply knowledgeable about one area of the district. Second, as a “treatment area” in the original Navrongo family planning experiment, Kalivio Aboenia and Kalivio Awenia had access to the CHFP program from the mid 1990’s onwards, making the region a good place to compare men’s and women’s perspectives on the relative impact of the family planning program and social and economic change on family size. Finally, Kalivio is part of Chiana and has a long history of well-documented social change (Cassiman, 2006; Howell, 1997) which would enrich my discussion of the impact of social and economic forces on the formation of the Kassena family.

The Kassena

The Kassena live in the Upper East Region of Northern Ghana and in southern Burkina Faso. In northern Ghana, they occupy Kassena-Nankana East and Kassena-Nankana West. The Kassena are one of two main ethnic groups in the region and comprise about 49% of the population; the Nankana comprise 46% and the remainder of the population (5%) is comprised mainly of Buli people (Dalaba et al., 2016). Anthropologists continue to debate the relationship between the Kassena and the Nankana. Some argue that the histories of contact, intermarriage and exchange between the two groups, as well as the similarities between customary rituals, such as marriages, funerals, and births, indicate that the

Kassena-Nankana can be referred to as one group (Awedoba, 1985; Abasi, 1993). My interlocutors think of themselves as a distinct group, thus, I refer to the people with whom I worked as Kassena³.

Histories of Migration and Change

While accounts of family planning among the Kassena emphasize the influence of public health programs on fertility decline (Dalaba et al., 2016; Philips et al., 2012), these accounts downplay the ways in which Kassena family life has consistently been affected by and embedded in both local and global political economic changes. The majority of the Kassena practice Christianity, while the remainder practice Islam or traditional religion, a form of animism and ancestor worship (c.f. Doctor, Phillips & Sakeah, 2009; Adongo, Phillips & Binka, 1998). The region's predominantly Christian population in an otherwise Muslim north reflects its history as the home of Catholicism in northern Ghana. Doctor and colleagues (2009) report from survey data collected in 2003 that 64% of women aged 15-49 professed Christianity as their religion, up from from

³Note the differences in spelling. The word 'Kasena' is used by several social scientists, while 'Kassena' appears in the public health literature on the region. For purposes of indexing, I use 'Kassena'.

35% in 1995.⁴ Nearly all young men and women included in the current study, as well as elderly and middle aged women, identified as Christian or Catholic, while it was more common for elderly and middle aged men to identify as traditionalists, or a combination of the two. Christianity is increasing, especially among the younger generation and among women (Doctor, Phillips & Sakeah, 2009).

Doctor and colleagues (2009) suggest that women who identify as Christians are more likely to use contraceptives than women who are traditionalists; they suggest that Christianity is linked with women's increasing autonomy in family and marriage. However, some Catholics and Christians will not tolerate 'artificial' forms of family planning such as injections, and abortion, and will only adopt abstinence or the rhythm method. In addition, some Christian or Catholic health professionals reportedly refuse to provide contraceptives or support abortion care. In Ghana, abortion is a criminal offence. The law permits safe abortion only if the pregnancy results from incest, rape, or "the defilement of a female idiot"; if the health of the woman is in danger, or if there is fetal abnormality.

Among the Kassena, and elsewhere in Ghana, abortion is heavily stigmatized, owing to both high levels of Christianity and Catholicism and

⁴In Ghana, researchers' estimates of women identifying as Christian often do not differentiate between women professing Christianity and women professing Catholicism

local understandings of fertility. While few Christians and Catholics adhere strictly to only abstinence and rhythm methods of family planning, negative perceptions of abortion are common. Men and women in K-N West and elsewhere in Ghana argue that killing an unborn child is a sin and can lead to childlessness.^{5,6} The following excerpt from a newspaper article in the Daily Graphic, written by Professor Agyeman Badu Akosa (2013), describes three women who sought illegal abortions and died. He claims that had they survived, they would have needed to seek forgiveness:

The doctor's duty would have been to counsel the woman to keep the pregnancy, but if they insisted, he would have offered them the option of surgical abortion...they would all have been alive to go to church and ask the Lord for forgiveness...(Agyeman Badu Akosa, 2013, p. 1).⁷

⁵ The Kassena believe that god provides each woman with a fixed number of children to conceive and when these children are aborted, this results in infertility.

⁶The stigma associated with abortion is also created by worries about the bodily impacts of back-street abortion. In describing their options for abortion, my interlocutors discussed the extreme treatments that women seeking an abortion often take. Since it is believed that a severe stomach upset will kill a fetus, common treatments are overdosing with paracetamol (aspirin) or mixing a drink with a malt, such as guinness beer, and adding sugar and a crushed glass bottle. It is common knowledge that these treatments occur at the risk of death.

⁷ In Kassena-Nankana West and East districts, abortion-related complications remain the leading cause of maternal mortality (Mills, Williams, Wak & Hodgson, 2008) despite the fact that abortion care is provided at the district hospital in Navrongo. In K-N West, every woman seeking family planning receives a pregnancy test since some women hope that contraceptives will help them abort.

Christianity has not only influenced opinions about abortion in the region, but many other aspects of society relevant to family size and family planning. When Catholic missionaries first arrived in the region in 1906 they immediately challenged polygynous marital customs and other beliefs around which family life was organized. Missionaries worked as agents of social change by developing schools where young people studied religion, science, European history, politics and technology. They introduced medical centers, which in turn enhanced the credibility of Christianity. At the same time, the process of colonization intensified migratory movements between northern and Southern Ghana. During the colonial period, the underdeveloped north was regarded as a cheap source of labour by the British and men temporarily migrated from the Northern Territories in the dry season to work in gold mines and cocoa farms in the south, then returned home for planting (Howell, 1997). Howell argues that as a result of the British presence, the town of Navrongo was developed at the expense of surrounding communities and officials only visited these communities to recruit labour. Today, old women in Kassena-Nankana West still recall being forced to carry gravel and beat roads, while men remember carrying wood and grass (Howell, 1997). The attitudes of colonizers towards the Kassena reflected broader sentiments towards people in the north: “they were regarded as an amiable but backward people, useful as soldiers, policemen and labourers in the mines and

cocoa farms; in short fit only to be hewers of wood and drawers of water for their brothers in the Colony and Ashanti” (Howell, 1997, p. 38). It was this history that supported a pattern of cyclical, semi-permanent and permanent migration, an ongoing reflection of the differences in development between Ghana’s North and South.

Wealth and Well-being in the North

Increasing socioeconomic inequalities between the north and the south of Ghana have been linked to both colonial economic policies and economic mismanagement that have occurred in the country since the late 1960s (Konadu-Agyemang, 2000). When Ghana gained independence in 1957 and the British left, the country was underdeveloped and production and consumption of commodities was geared towards external trade rather than self-sufficiency. By the 1960s, the country’s economy was shifting closer to bankruptcy. Bolstered by political instability and corruption, Ghana’s economic problems continued through the 1960s into the 1970s and 1980s, leading large numbers of skilled professionals, including teachers and physicians to leave the country. It was this negative situation that brought the Bretton Woods “doctors”, the IMF and the World

Bank and their structural adjustment programs⁸ to the scene (Konadu-Agyemang, 2000).

Figure 4: The Basilica in Navrongo overflows with worshippers on a Sunday. Photograph by L. Wallace, 2013.



Ghana has been hailed as one of the most successful cases of structural adjustment in Africa. In 2010, Ghana reached the milestone of

⁸ Structural adjustment programs or SAPs are the neoliberal policies negotiated by International Financial Institutions such as the IMF and the World Bank with Ministries of Finance at a country level. Originally introduced in the 1980s, they include a package of actions geared towards economic growth such as currency devaluation, downsizing the public service, and decreasing government expansion of education, health and welfare programs (Pfeiffer & Chapman, 2010).

Middle-Income Country status a decade earlier than planned based on a statistical recalculation. After a GDP rebasing exercise in 2010, the World Bank announced that Ghana's official GDP per capita was not under \$800 as previously thought, but rather \$1,363, and the region was upgraded from a Low-Income Country to a Middle Income Country virtually overnight (Moss & Majerowicz, 2012). While the IMF argues that the economy is growing, this evaluation has not gone down well with academics, business owners and citizens. Even after being upgraded to middle-income status, Ghana's economy is in dire straits with above normal public debt, an energy crisis, wage declines as a result of rising inflation, a dependence on imported goods, and dropping export revenues. The prices of basic goods such as sugar, fuel, and transportation costs have skyrocketed. During the interval between when I left Ghana in December 2013 and returned in February 2014, the price of *tro-tro*⁹ transportation from Kalivio to Navrongo had increased by one cedi, a significant price hike for rural families who need to travel to Navrongo to reach the district hospital.

While SAP-derived improvements in the national economy are recorded at the macro-level, whether their benefits are felt equally throughout Ghana is a matter of considerable debate. Evidence suggests that the success of structural adjustment has been uneven in Ghana and decades of economic reforms have not ameliorated regionally-defined

⁹ *tro tros* are privately owned, shared minibus taxis that travel fixed routes.

socioeconomic disparities. This has been demonstrated not only in Ghana, but in many countries who have taken the IMF “medicine” (Konadu-Agyemang, 2000).

Residents of the south of Ghana continue to be relatively better paid, educated and healthier than their northern counterparts in the Upper East, Upper West, and northern regions. The most recent Demographic and Health Survey shows that both men and women in the northern part of the country are at a disadvantage educationally (GHS & GSS, 2015). For example, the percent of women aged six and over who have never been to school in the Upper East region is close to 45%, compared with only 14% of women in the Greater Accra region; similarly, only 1% of women in the Upper East region have completed more than secondary school, compared to 10% of women in the Greater Accra region. The pattern for men mirrors that of women, with 32% of men in the Upper East never having been to school compared to only 8% in the Greater Accra region.

Child and infant mortality rates, used as indicators of overall socioeconomic development, health status and quality of life, also vary widely in Ghana, depending on geography. Nationally, infant mortality declined by 28% between 1998 and 2014 and under 5 mortality decreased by 44% over the same period (GHS & GSS, 2015). According to estimates from WHO (2015), maternal mortality also declined during this time, from

634 to 319 between 1990 and 2015¹⁰. However, under 5 and maternal mortality remain the highest in northern regions of the country. In 2014 the GDHS estimated that the infant mortality rate in the Upper East Region was 46, compared to only 37 in Greater Accra. Similarly, in the Upper East Region under 5 mortality was estimated at 72, and 47 in Greater Accra (GSS & GHS, 2015).

There is a strong connection between social determinants of health, such as literacy rates, infrastructure, and child health, nutrition and mortality, in Ghana. For instance, there is a tight relationship between lack of access to healthcare facilities and personnel and high mortality rates in northern Ghana. Physicians prefer to live in the more developed southern parts of the country. While there is one government-employed physician per 5,300 people in the Greater Accra region (south), there is only one physician per 64,000 in the north (Konadu-Agyemang, 2000). The case of Aminata, a 35 year-old woman from Sissala East district in the Upper West region, represents just one example of the risks to which women in the north are exposed in childbirth, due to lack of infrastructure and personnel. In the *Daily Graphic*, Nunoo (2013) reported that after a five

¹⁰ Maternal mortality is estimated based on the number of deaths of women who are pregnant or within 42 days of termination of pregnancy per 100,000 live births. Maternal mortality estimates in Ghana vary widely, depending on the source. The Ghana Maternal Mortality Survey reports lower rates of mortality than organizations such as the World Bank and WHO, however, in country calculations are expected to be estimates since they do not capture maternal deaths outside of health facilities.

hour drive on unmotorable roads, Aminata had abnormally high blood pressure. When she arrived at Tumu hospital, she was bleeding profusely from a ruptured uterus and had lost more than 12 pints of blood. She was fortunate that the only physician working at the hospital was on duty, and despite the non-existence of other critical health staff such as anaesthetists, her life was saved.

Today, harsh climate conditions, lack of fertile lands, food insecurity, unemployment and continual lack of development in the north make urban centres in the south attractive and trigger both temporary and permanent outmigration in increasing waves – even if the reality of life in the south is much more difficult than imagined (Cassiman, 2010). The city is particularly appealing to Kassena youth. Migration is increasingly feminized with young women leaving their homes to earn quick money as porters, food sellers or maids; these women follow their husbands, meet relatives in the cities or go alone. This migration trend has exposed people to new ways of thinking about family life, but has also brought about economic hardship and the separation of family. I elaborate on some of these changes and their impact on family life and family planning practices in K-N West in the ensuing chapters.

Economic Life

In the rural areas in which I conducted fieldwork, the Kassena practice subsistence farming. The main crops grown include guinea corn, beans, rice, groundnuts, and millet. In addition, most families also rear animals such as cattle, sheep, pigs and poultry, including guinea fowl and chickens. Animal husbandry serves many purposes, including ritual sacrifices and gifts and compensation for work done. For example, fowl are commonly provided in bridewealth negotiations and are given to visitors to express hospitality. Animals are also sold for profit when food reserves are low at the end of the dry season, when households must supplement their diets with purchased food. In 2013, I observed that many families had eaten or sold the majority of their food by April, leaving them with six months of hunger until the next harvest, and a dependence on purchased food items. In this sense, livestock rearing is no longer an “alternative livelihood” strategy, but a necessity for survival.

Cattle are the highest valued livestock in the market. In the past, the ownership of large herds of cattle was common and gave the owner prestige and economic status. Today, however, shepherd boys and girls are few and far between, owing to the impact of compulsory schooling and high rates of cattle theft in the region, which make raising cattle without a shepherd inadvisable. Raising less expensive animals such as sheep, goats and fowl remains a precarious enterprise, though, because of high

rates of infectious diseases and the expense and difficulty of accessing vaccinations.

The Environment

The Kassena live in a hot, dry environment with a short growing season that extends from April to October. The land is flat, often rocky, semi-arid grassland interspersed with small groves of acacia, baobab and dawadawa trees. The Kassena practice mixed cropping and mixed farming, in which different types of crops are farmed on the same land, and crop residues are used for feeding the livestock; when the livestock feed, their droppings are turned as manure. As a result, farmlands are used intensively, leading to land degradation and poor soil fertility and productivity. Formerly, the region was filled with trees; however, bush burning, felling trees to create charcoal for selling and cooking, and livestock grazing have gutted the landscape (Howell, 1997).

The Kassena recognize two main seasons, the dry season (*ti-ponga*) and the wet season (*yaade*). In the wet season, the landscape is verdant and the grass grows up to three metres high in some places (Howell, 1997). Climate change has shortened the rainy season considerably, delaying rains, and making their patterns increasingly erratic and a continual source of worry; currently, long droughts frequently lead to crop failure.

The rainy season is the busiest season and work begins at sunrise and ends at sunset; it is also often a period of food shortage and hunger since by this time the food from last season has been exhausted and both men and women participate in backbreaking labour, often on an empty stomach. One of the young women I worked with, Kadua, has four children and was in her third trimester of pregnancy during the last wet season. I watched her exhaust herself carrying out all of her household chores. On most days she would not eat until dinner and reserved the food that I shared with her for her children. At the beginning of the farming season when food supplies and energy levels are low, some young men resort to taking stimulants bought from local markets, an added risk to their health along with their already inadequate nutrition. During the wet season, little attention is given to communal rituals such as funerals, which are often postponed until the dry season. Drumming is banned, since it is believed that doing so creates storms that will damage growing crops.

In the wet season, men focus on farm work and rearing animals. Aside from small household farms, many men also clear land in the bush. Men often arrange for their relatives and friends to help them farm communally on a specific day; food and alcoholic beverages are provided in exchange for labour. In addition to farming, women are in charge of sowing vegetables along the borders of farmland and paths around their homes, gathering firewood and *shea* nuts, cooking, caring for their

children and cleaning their houses. Land owners sometimes provide farmland to women (Cassiman, 2006), which they use to grow crops, such as groundnuts (peanuts) and beans, to generate their own income.

Figure 5: Young men weed groundnuts. Photograph by L. Wallace, 2013.



The dry season, which can last almost eight months of the year, is taxing for communities. The Kasem name for the dry season, *ti-pongo*, which literally means “empty white earth”, perfectly describes this period in which there is no rain (Abasi, 1993). Crops cannot be grown, except in small gardens irrigated by hand. One can easily become dehydrated, as temperatures during the day often exceed 40 degrees Celsius. However, the nights are cooler and some relief is provided during the day by strong *harmattan* winds that blow across the land. As a newcomer to K-N West

experiencing my first dry season, I found the hot sun, dust and dryness during this period suffocating and physical activity unbearable.

Figure 6: A grandmother works to build a new room in her brother-in-law's compound in the dry season. Photograph by L. Wallace, 2014.



During the dry season, boreholes are used to obtain water for domestic use, irrigate small gardens and water animals. As a result, boreholes can dry up, making moisture even more difficult to come by. Although men and women do not farm during the dry season, they are busy conducting communal rituals like funerals, drumming, and dancing.

Families build new rooms for their houses and repair those that fell down or were damaged by the rain in the wet season (Figure 6); at this time, young men also migrate south to find work.

Just as work displays a seasonal pattern, so do births. Osei and colleagues (2016) found that more women in Kassena-Nankana East and West gave birth in the rainy season than in the dry season. The monthly distribution of births peaks in May, September and October. Osei and colleagues suggest that a lower birth rate in the dry season could reflect seasonal environmental conditions, in which fewer women may choose to access healthcare facilities in the dry season due to the stress of walking for long distances in the sun.

Social and Political Organization

Kassena communities are organized in clan-settlements and descent is patrilineal and patrilocal. Typically, a clan is made of a number of households located close to a piece of land owned by the clan. Although compounds of major lineages tend to occupy specific areas, compounds (*sono*) of different clans are intermingled for various reasons. Rather than being organized in clustered villages, homes are dispersed throughout the landscape, situated at the confluence of different walking paths, and surrounded by small plots of farmland.

Figure 7: Compound with a mix of laterite (mud) and cement block rooms in K-N West. Photograph by L. Wallace, 2014.



Every compound is composed of laterite and is made up of a series of round or rectangular, flat-roofed rooms joined by an outer wall with a single entrance. Each compound traditionally has a kraal (*naboo*) in the centre, where goats, sheep and cattle stay at night. Each household also has hen coops for fowl. Just outside of the gate, many people build a small shelter with a shaded log bench where visitors or household members can rest. Most of the activities conducted by women and girls, especially cooking, occur in the courtyard(s). More recently, some dwellings are constructed with rectangular rooms made out of cement blocks, which are

considered modern; this has changed the typical look of houses (Figure 7). While these homes are more durable, they offer sharp contrast to homes in Accra, in the south of the country, or even some houses in Navrongo, which have electricity and air conditioning and are guarded by hired watchmen (Figure 8).

Figure 8. Home in Haatso, Accra. Photograph by L. Wallace, 2013.



Large compounds usually consist of a man and his wife (or wives), and their children, the man's brothers and wives and children, and their elderly parents. Due to migration, increasing monogamy and preferences for nuclear family living arrangements, household membership size has declined in recent years. During my fieldwork in 2013 and 2014, the

compounds contained an average of seven members and often consisted of a man, his parents, his wife, and their children. The largest compound in my study area was occupied by the Chiana chief, whose father had twenty wives; his compound consists of over eight hundred members.

The *songo-tu* or household head carries final responsibility for all household matters. He is the authority on all ritual matters such as marriage and funeral practices (Cassiman, 2006). As the senior authority and an extension of the ancestors of the house, he also settles disputes within the compound and enforces correct behavior (Howell, 1997). The *songo-tu* is also responsible for consulting soothsayers on matters of importance and making sacrifices to ancestral spirits at the compound's shrine (Adongo, Phillips & Binka, 1998). When the *songo-tu* dies, land is inherited by and divided between his brothers or sons. While Kassena men often hold positions of leadership in the community, Kassena women cannot hold offices such as land custodian, or lineage head, chief, village elder or soothsayer.

In Kassena society, central authority rests in the chief, who is assisted by a council of elders who are normally lineage heads. The chief is responsible for the welfare of his community and presides over religious rituals; together with his council of elders, the chief forms the traditional court, which oversees land disputes, family feuds, and marriage compensation (Abasi, 1993). Some influential chiefs, such as the Chiana

chief, are even responsible for arbitrating cases of serious crime. Today, chiefs fall under the authority of the government, and act as an arm of the state (Cassiman, 2006).

Health System Structure

The health system in Ghana utilizes health centers and community health compounds as referral points for hospitals. Community health compounds have resident nurses who act as community health officers (CHOs) and offer doorstep services to community members (Nyonator, Awonoor-Williams, Phillips, Jones & Miller, 2005). In collaboration with donors such as the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID) and the World Bank, Ghana has implemented several projects aimed at improving family planning coverage. According to the most recent GDHS, among currently married Kassena women, 25% currently use a method of family planning; in comparison, 27% of married women nationally use contraceptives. The most commonly used effective methods in the Upper East Region are injections and implants, followed by the pill (GHS & GSS, 2015).

Family planning programs are funded by the Ministry of Health, but since government funding for contraceptives remains inadequate, they are provided by the United Nations Population fund at highly subsidized prices. To enhance the affordability of contraceptives for the general

population, the government of Ghana recently passed a law to allow the cost of contraceptives to be covered by the National Health Insurance Scheme. Unfortunately, at the time of writing the law has not yet been implemented. Both the public and private sectors play important roles in providing contraceptives in Ghana. Whereas the majority of users of injectable and implant methods obtain them from a government source, non-clinical, short-term methods, such as pills and condoms, are widely distributed from pharmacies in the private sector (GHS & GSS, 2015).

Marriage and Family-Building

In Kassena society, as in other patrilineal societies, marriage is expected to be a process that culminates in childbirth, preceded by the movement of the woman from her natal home into her husband's compound. The Kassena terms reflect this process. To ask a woman if she is married, one uses the question *mo zo barrana?*, which literally means have you entered into your husband? Although the announcement of a woman's marriage is made once the bride enters the husband's home, during the preceding period and after the marriage has been announced, gifts are exchanged between the couple's families.

Since marriage is viewed as a relationship that unites two families and clans in an alliance, families launch a serious pre-marital investigation to decide whether a couple should be allowed to marry. It is of utmost

importance to establish whether or not the two families are related. The health and social background of the other family is analysed. Diseases and conditions considered to be social vices – including leprosy, HIV, blindness, albinism, thievery, and alcoholism – must be avoided.

Marriage becomes possible when a Kassena man and woman unite in friendship and fall in love. Couples commonly meet each other at the market, funerals, and church. The Kassena describe a loving relationship as one in which there is mutual understanding, respect, and common goals and aspirations. They understand that in a situation in which a woman does not love her husband, the marriage is likely to result in unhappiness, quarrels and divorce. Love and attraction between the man and woman are believed to contribute to a successful partnership.

Polygamy was more common in the past; in 1995 more than 44% of women aged 15-49 were in polygamous relationships (Doctor, Phillips & Sakeah, 2009). A woman's parents influenced her choice of partner. She was sometimes promised by her father to a friend, or given to her older sister as a maidservant (*kanyaane*), with the expectation that she would assist her sister with household chores and marry her sister's husband, a type of sororal polygamy (Cassiman, 2006). Maidservant marriages are rare today, owing to the increasing recognition of the importance of education for girls and the decline of polygamy due to increasing

conversion to Christianity. In the communities in which I worked, only 20% of married women aged 15-49 were polygamous.

Marriage by capture is also in decline. In these situations, a woman is seized by a young man, who is often assisted by his friends. This is a dramatic spectacle that frequently occurs in a public place like the market. In one case I encountered, a woman was captured at the market, taken to the man's home, tied up and not released for three days. Today, most young women freely choose their own husbands.

Value of Children

The Kassena consider the production of children to be one of the primary purposes of marriage. Children have a wide range of social and economic benefits, especially in rural areas. In the patrilineal system, children ensure the perpetual existence of the lineage. Perhaps most importantly, children are assets for completing tasks in the home, on the farm and for the overall benefit of the community. While boys and girls assist with weeding crops, boys are given tasks like collecting insects to feed the fowl, watering and herding animals; girls are responsible for caring for younger siblings, fetching water, sweeping the courtyard and washing dishes. In this rural setting where few individuals have formal, salaried jobs with pensions and benefits or social insurance, the

household labour and remittances children provide to families are significant.

Children are also important for the performance of funerals. Funerary rituals display the marital and parental status of the deceased, and certain rites are only performed if the deceased is married and has children (Abasi, 1993). Children ensure a grand funeral celebration with many people in attendance, which signifies a life well-lived as well as good future prospects for life in the ancestral world.

No matter how rich or successful he or she may be, a childless person is generally considered useless, and not fully-grown or fulfilled in life. Infertility is considered to be a terrible fate linked to poverty. Childless people have modest funerals. What's more, childless individuals evoke pity, gossip, insults and accusations of witchcraft. In northern Ghana accusations of witchcraft are referred to traditional leaders for a decision. However, rough justice and mob violence can frequently drive a woman from her home, her family and her community. If she is lucky, the woman accused of witchcraft will find her way to one of the "witch camps" that dot northern Ghana and offer respite and sanctuary to these displaced and persecuted women. Hearing about witchcraft from friends and co-workers, and marvelling at its frequency on Ghanaian television, in July 2013 my colleague Dr. Jacqueline Murray and I set out to visit one of northern

Ghana's oldest witch camps, which houses 130 women, in the town of Gambaga (Wallace & Murray, 2014, Murray & Wallace 2013).

Figure 9: Women's homes in the Gambaga witch camp. Photograph by L. Wallace, 2013.



We first visited with Takira Mutaru, the *magazia*, or leader of the camp. Rather than discussing her personal experience, which was too painful to recount, she told us that “my time at the camp has given me peace, freedom from the accusations and disturbances at home. Here it is safe.” The general atmosphere of the camp was pleasant and well cared for but the poverty was evident. Many of the women were dangerously

lean and wore ragged old clothes. On 18th June 2014, the United States Ambassador to Ghana Gene Cretz announced that the United States would collaborate with the Ghanaian government to disband the witch camps in the Northern Region; however, destroying the witch camps, the only safe havens for accused women, and sending them back to the villages that rejected them, will certainly exacerbate their vulnerability (Wallace & Murray, 2014).

Methods

In June 2013, five months before beginning my PhD thesis research, I traveled to northern Ghana and conducted two weeks of exploratory pilot fieldwork in Navrongo. I visited the School of Public Health at the University of Ghana in Legon to meet with Dr. Philip Adongo. While at the NHRC, I met with the Director of the Navrongo Health Research Centre, Dr. Abraham Oduro, to discuss the logistics of my fieldwork and to present my research proposal to staff at the centre. During this time, I became familiar with the workings of the NHRC and was advised by local researchers about important sociocultural considerations which assisted me in developing my proposal and ethics application (see Appendices J and K).

Phase one. When I arrived to begin fieldwork in the Upper East in June 2013, my study materials had not been completely translated into Kasem and Nankam. This delay turned out to be fortunate because it gave me the opportunity to participate more fully with researchers at the NHRC and to benefit from their suggestions and ideas. While I was waiting for approval from the NHRC's ethics board, I presented my research proposal to staff at the Centre who made several useful suggestions about organizing focus groups and compensating participants with soap and food. Some researchers objected to the idea I presented that family size was still too high in the district. Through valuable conversations with researchers at the NHRC, I became interested in investigating fertility decline in the district, rather than focusing on the region as an area of high fertility, as it is often presented in the literature.

I also used this time to train my research assistant, Aurelia Abapali, a young Kassena woman assigned to my project by the research centre. Aurelia has nearly ten years of working experience on various health projects in the region, and a degree from the University of Development Studies (UDS). Aurelia was an invaluable asset to my project. Although she had not assisted with an ethnographic project before, she was quick to learn. During this time, I also began to collect clippings from the national newspaper, the Daily Graphic, to learn more about health, development and family life in the region. I also consulted with Dr. Adongo, as well as

Dr. James Phillips¹¹ and Dr. Cornelius Debpuur¹², to determine where I should conduct my research.

Language training. In June 2013, I began taking lessons in the local language, Kasem. My willingness to learn the local language was especially useful in facilitating my entry into the field. As Katherine Dettwyler (1994) describes, language is a source of immense power. It is not only an asset for surviving on a daily basis but it is key to gaining acceptance in a community. My effort to speak Kasem was particularly valued by my interlocutors and staff at the NHRC, since many Ghanaian residents from the south of the country, and even members of other northern ethnic groups, do not try to learn the language. Learning Kasem is thought to be especially difficult since it is a Grusi language that differs from other languages spoken in the north and is more closely related to languages spoken in Burkina Faso.

¹¹ James Phillips is a Professor in Population and Family Health at the Columbia University Medical Centre. He was a major collaborator in designing the Navrongo experiment and is a leading scholar in implementing tools for evidence-based scale-up of health system innovation.

¹² Cornelius Debpuur is a social demographer and research fellow at the Navrongo Health Research centre who worked extensively on the Navrongo Project. He has expertise in general population dynamics, adolescent reproductive health, health equity, adult health and aging, and social determinants of health.

Learning Kasem greetings was particularly valuable. Greetings are an indispensable part of daily life in northern Ghana. When you meet someone you know, or even a complete stranger, it is a sign of politeness and respect to greet them. This involves a series of questions, which can cover the well-being of their health, their family and their work. Some standard greetings are:

1st speaker: Denlei [Good day]

2nd speaker: Denlei. Koyehteh? [How is it?]

1st speaker: Kogarah [Fine]. se mo deyerane? [How are you also?]

2nd speaker: Kogarah [Fine]

1st speaker: N jeje yizura? [Do you have health?]

2nd speaker: Yizura wora [I'm feeling fine]

1st speaker: Ma vei yeh mo? [Where are you going?]

2nd speaker: A ma vei a VAST mo [I am going to VAST]

1st speaker: N vwo sa bena [go and come]

Through the analysis of Kasem proverbs and expressions, I also gained a deeper understanding of the cultural images and concepts that inform daily life, and in turn, Kasena families.

Of course, learning a new language is not easy. Since people did not expect a foreigner to speak Kasem, they did not always understand me the first time I spoke to them because they were expecting to hear English. For example, one morning, I greeted a woman in Kasem and she

responded back, “I don’t speak English”. When she realized I was trying to speak Kasem to her, we both had a good laugh.

Since Kasem is a tonal language, speaking it well requires knowledge of the multiple meanings of similar words. Knowledge of Kasem also requires an understanding of complex verbs and expressions, especially when speaking to elders. As Ann Cassiman writes: “The Kasena themselves are very proud of their elegant use of metaphoric and figurative language, in particular, when communicating with the elders, one’s ability to play with metaphors and figurative meanings in one’s sayings not only displays one’s wisdom and experience, but one’s insight into the twists of life” (Cassiman, 2006, p. 27). By no means did I become fluent in Kasem, however, my proficiency in basic phrases and terms served me well.

People often asked me to teach them some English in exchange for the Kasem phrases they taught me, which I was happy to do. My interlocutors, however, were never quite able to understand the pronunciation of my name. After a few months of fieldwork, I was given a Kasem name, Wεpia, by Diana Abagale, Deputy Administrator at the NHRC. My local name further facilitated my entry into the community. Wεpia means god’s gift, a reflection of my kind nature.

Entering Kalivio. My official entry into Kalivio was fairly seamless because I was a researcher affiliated with the NHRC. The NHRC has been conducting research in the district for over two decades. Most residents of the district have participated in at least one research project. Since the centre has a long history of working successfully with local communities, it has significant cultural capital. Locally, the centre is known as VAST, which refers to its origin as a field site for a Vitamin A supplementation trial in 1989. This acronym, recognized and used by even those who do not speak English, provided an easy way to explain my role to people I greeted in the community.

During my transition into the communities, I only encountered resistance to my research project once. A sub-chief and group of families had a bad experience with researchers from a local university. The families felt they had been misinformed about compensation for participating in the research and expressed concern about the benefit of the research to the community, especially since they had not received copies of the study results. To prevent similar mistakes, I provided in-depth responses to their questions and concerns during the informed consent process.

Consulting community leaders. The process of consulting community leaders about research activities in their communities follows a

long-established protocol in Ghana, which involves first visiting the chief and paying respect to him through the presentation of small gifts of cola nuts, and a bottle of spirits (Tindana, Kass & Akweongo, 2006). Before beginning my research, I gained permission from the chief of Kalivio in Aboenia and from the sub-chief of Kalivio Awenia. I also met with the Paramount chief of Chiana, the larger settlement of which Kalivio is a part. As a visitor to the community, I was given a gift of chickens, which Aurelia and I cooked into a delicious soup.

At the start of my work in Kalivio, I also met with the assembly man for the village who helped me map out the community. His assistance allowed Aurelia and I to determine where the major landmarks in the community were located, such as the health clinic, community health compounds, schools and market square. I also visited with the nurse in charge at the local community health compound.

At the outset of my field research, Thomas Adialo, the Chief of Chiana, kindly provided from his library several books written by anthropologists who have worked in the region. He also introduced me to two key women who provided useful insider knowledge about changes in family life and development in Chiana: Allison Howell, an ethnographer and current Dean of Research at Akrofi Christaller Institute of Theology, Mission and Culture, who first worked as an anthropologist and a missionary, and Sister Pat, an American nun, who has lived and worked in

the region for more than 30 years. Through the NHRC, I was also introduced to Francis Augustine Asare, a Reverend and retired anthropologist who worked at UDS on funerary rituals. I met Reverend Asare for tea at his home and he kindly provided me with a copy of his dissertation and valuable mentorship on working in the district.

Genealogies. I conducted my ethnographic fieldwork using a range of methods and participants, which are described in detail in the body of my thesis and in appendices. I started collecting genealogies in July 2013 (See Appendix A). Genealogies provided useful information about household composition and family formation, in preparation for more in depth discussions during interviews and focus groups. Collecting genealogies, moreover, proved to be a non-threatening way to get to know families, since asking about basic family information is not considered to be as intrusive as collecting information about contraceptive use. I collected 25 genealogies in total, which encompassed 323 individuals. Each participant was provided with a bar of soap.

Participant observation. I started participating in a number of activities in the community as soon as I began fieldwork, including farming, cooking groundnut soup and *kenkey*¹³, and carrying water and firewood. I

Figure 10: Carrying a “light” load of firewood for the first time. Photograph by Aurelia Abapali, 2013.



¹³ Kenkey is a food prepared from fermented maize.

often provided food for participants to share in exchange for the time they spent with me. Although I interviewed men and women for my study, as a female, I gained rapport more easily with women. As a result, I spent more time hanging out and engaging in activities with women than men. Initially, people were perplexed by the concept of participant observation and were reluctant to let an educated white woman share in their daily tasks.

While they did not express it directly, some people understandably had reservations about my ability to properly conduct important tasks like farming. In one case, a woman told me she would be farming the next day. When I arrived at her house to assist, she said that it was too cold to farm, but began to do so after I left. Evidently, she was worried that I would botch the job.

Many of my interlocutors were worried about my well-being when I expressed an interest in assisting them with housework or farmwork. It is well known in northern Ghana that white people do not participate in much manual labour. White skin is seen as soft and less able to withstand harsh conditions. When I finally started to participate in daily activities, it was a source of amusement for the community. Children screamed with laughter when I could barely carry a 'light' load of firewood more than a few metres (Figure 10). The first time I tried to clean my teeth with a chewing stick from a neem tree, I could barely keep the stick in my mouth because it

was so bitter. While the men and women watching were laughing, I felt frustrated and embarrassed.

As time went on, I became more skilled at farming tasks and my presence in the community became more routine; however, my white skin still left me marked by difference. I could not walk down the street without children singing the *fieleh* [white person] greeting song: “*fieleh fieleh* good morning, *Kassena Kassena dinwaaro*”. The song literally translates into: The white people say good morning, the *Kassena* people say *dinwaaro*. While sometimes the song was sung quietly, it was often shouted in a spirited display accompanied by marching and clapping.

Focus groups. After I completed the genealogies and was well into participant observation, I began to organize focus groups in July 2013. I approached potential participants based on the genealogical information I had collected, which made it possible to recruit individuals from a wide variety of family sizes, education levels and socioeconomic statuses in each age category. Socioeconomic status was assessed based on observation, with assistance from Aurelia. Focus group guides are detailed in Appendices B, C and D.

The groups consisted of men and women from different age groups: unmarried youth, young married people just beginning to have children, middle-aged married individuals almost finished having children

and older married people who were finished childbearing. I wanted to understand the perspectives of different age cohorts or generations on the ideal number of children in a family and on contraceptive use, in order to gain a sense of changes in family planning strategies through time. Eight focus groups were completed in Kalivio aboenia. For purposes of comparison, I also completed focus groups with young men, young women, and older women in Kalivio awenia. In order to compare my results to earlier surveys conducted by Adongo and colleagues (1997), I used the same set of questions about women's autonomy, which covered issues such as men's perspectives on whether or not women could decide to limit family size on their own and whether they were permitted to refuse sex with their husbands, and leave their compound, sell produce or livestock, or adopt family planning methods without their husbands' consent.

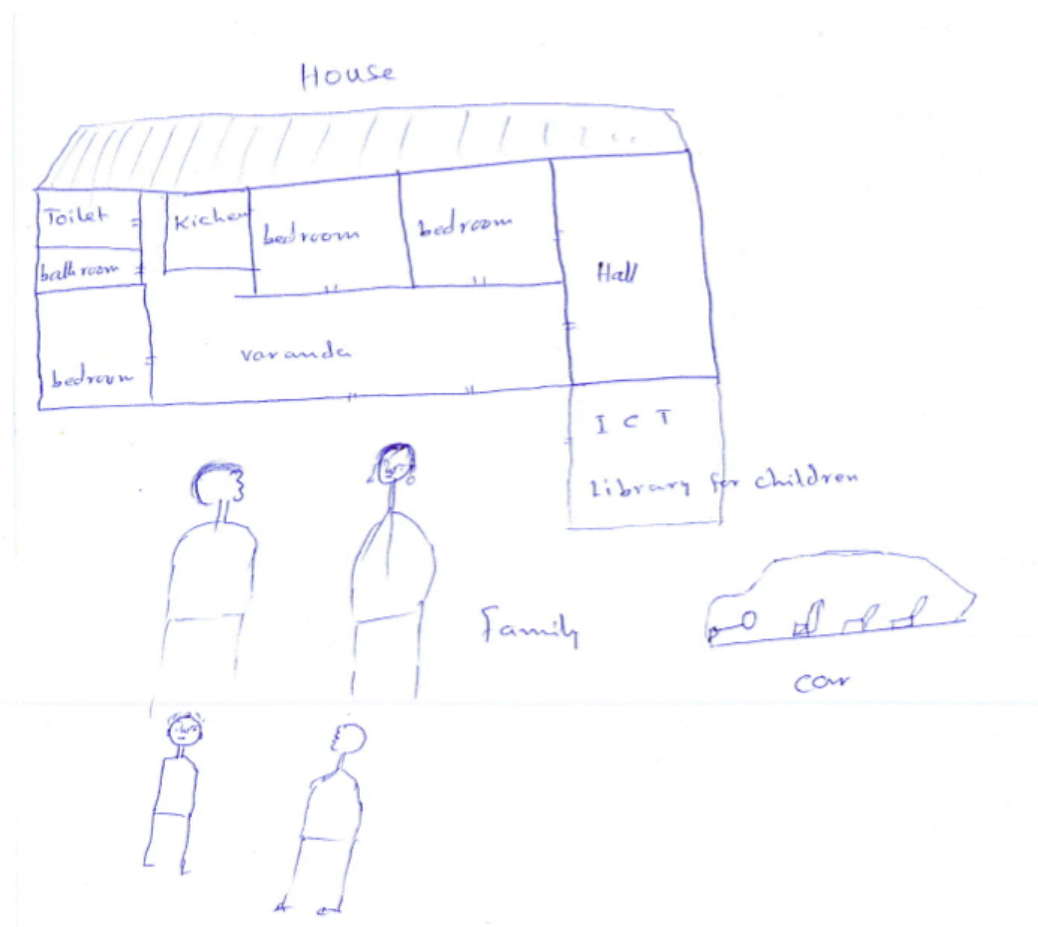
Focus groups were conducted in the shade under a large baobab tree, in the yard of an unused compound, or in an empty schoolhouse usually in the afternoon, a time agreed to by participants. Focus groups were moderated by Aurelia. Her brother David was hired to take written notes. Sessions were tape recorded and later transcribed by Aurelia. Participants were provided with a bar of soap, food, and water.

Interviews. I conducted fifty semi-structured interviews with equal numbers of men and women and sought to include interlocutors from each stage of family formation. This sample included eight young and middle-aged husband-wife pairs (interviewed separately). Interlocutors were asked about their views on marriage, the benefits of children, and plans for their future families, including their opinions on family planning and whether or not they were currently using contraceptives. In addition, one interview was conducted with an agricultural officer. He was asked for his views on changing agricultural practices in Chiana and the impact of recent policies and environmental changes on families. For interview guides, see Appendices F, G and H. Interview participants were compensated with a bar of soap.

I returned to McMaster University in December 2013 after the first phase of my research was completed. During that time I conducted data analysis and literature searches. I resumed fieldwork in mid-February 2014 in order to conduct follow-up interviews and to observe dry season activities. Interviews were tailored to address gaps or explore interesting questions raised in the previous interview. In addition, participants from the husband-wife pairs were asked a series of life history questions in order to explore their childhood, perceptions of an ideal family, and their hopes and dreams for their family's future. If they wished to do so, they

were invited to draw a picture of their ideal family to begin the interview
(See Appendix H and Figure 11).

Figure 11: A young father's drawing of his ideal family.



Typical genealogical approaches involve the researcher drawing kinship diagrams to represent the relationships between family members. However these methods are not particularly participatory and do not reflect the way interlocutors think about their families. I asked participants to draw their own version of what family meant to them as a way of getting a

better understanding of interlocutors' own perspectives on family relationships.

“Expert knowledge”. Although my label as a researcher working at VAST made my transition into the community easier, my research methods often puzzled my interlocutors. A number of diverse research projects exist at the NHRC, however ethnographic projects are rarely conducted. Survey-based research, inherited from demographic and public health approaches, continues to predominate in the region. A large number of international researchers move through the centre, however they often work on short-term contracts as consultants for global actors such as the World Bank. For university-based researchers, engagement with communities is often mediated through local research assistants who collect the data. Since the 1990s, a handful of ethnographers have worked in the district, however, most have not focused on public health topics.

In this regard, the relatively long duration of anthropological research, qualitative methods and style of community engagement was perplexing to some of my interlocutors. Peoples' responses to my research methods were an indicator of the power dynamics between health professionals and communities that had typically been at work. When I asked men and women to share their perspectives on changing family size with me, they often asked for my opinion on various topics;

because of my level of education and Western background, some struggled to understand why I was consulting them and recording their knowledge. For example, in focus group discussions about family formation, some women asked “how many children do you think is a good number for us to have?” I responded that my role as a researcher was not necessarily to give advice but to understand how family-making was changing from the perspective of local people.

Health workers. For a period of approximately two and a half months, beginning in November 2013, I observed the daily activities of health workers and their interactions with patients who visited one family planning clinic and two community health compounds. Since most women attended the larger family planning clinic rather than their community health compound, because it was less conspicuous to do so, I focused my time at the family planning clinic. By doing so I was able to observe more interactions between women using contraceptives and health workers. During my time at the community health compounds, I went on several home visiting sessions with community health nurses. I observed nurses delivering several family planning education sessions to women, and in some cases, to women and their husbands. I also attended one child welfare community outreach conducted by the Chiana health centre,

where mothers brought their babies for weighing and received family planning education.

I conducted one focus group discussion with six nurses involved in the provision of family planning services. Nurses were asked to discuss their perspectives on the benefits of family planning and the challenges to promoting family planning, both in terms of barriers at the level of the health system and the community (See Appendix E). The focus group lasted two hours and took place at the health centre. Nurses were provided with food and money to cover transportation expenses.

I interviewed two directors and one coordinator working at the Ghana Health Service. Semi-structured interviews that lasted between fifteen minutes and one hour were conducted in a location agreed on by the participant. Policymakers were asked to discuss their perspectives on the benefits of family planning and challenges to delivering family planning services in terms of the barriers at the level of the health system and the community (See Appendix I).

Field notes and data analysis. At the end of each day, I recorded the information gleaned from interviews, focus groups, genealogies, and field notes. Data were coded using Nvivo 10 for windows. First, data were analysed using open coding, in which the data set was fractured by identifying chunks of data that relate to a concept or idea. For example, all

information related to the shifting costs of children was coded “Taking Care of Children”. Next, these concepts were organized into thematic categories using axial coding. For example, the category “Taking Care of Children” was subdivided into several categories that reflected specific costs, such as education, food and healthcare. These thematic categories were further developed using quotes as illustrative descriptors.

Figure 12: Study results are disseminated at a durabar in K-N West.



Knowledge translation. In March 2014, I presented a preliminary analysis of my findings in two community *durabars*, one for Kalivio awenia

and one for Kalivio aboenia. *Durabars* are community gatherings convened by chiefs and elders, used to share knowledge and mobilize community action. This form of dissemination of project results and celebration of the study was decided upon in consultation with members of the NHRC and the community. All members of each community were invited to attend the fora as well as health workers from the respective community health compounds. A tent and chairs were rented from Navrongo.

The meeting began with the community leaders, including elders, chiefs and sub-chiefs, entering to the sound of drums. After the key findings were presented by Aurelia and me, the floor was opened for men and women to provide their feedback and ask questions. After the discussion, food and sachet water were provided, purchased with my research funds, and the drumming and dancing continued. My results were well-received by the community. These fora also provided time for men and women to ask questions about the research; many of their questions centred around family planning methods, which generated some interesting intergenerational discussion and debate.

I also presented my preliminary findings to staff at the Navrongo Health Research Centre. Following the formal defence of this dissertation, a copy of the thesis will be provided to the NHRC and the Chiana Paramount chief for inclusion in their libraries. Along with a copy of the

dissertation, a short report will be prepared for the Kassena-Nankana Health Service Office in Paga, as well as for the regional office at Bolga.

This chapter has situated my study of family planning among the Kassena within local experiences of social history and research more broadly. Social and economic changes such as experiences of colonization, structural adjustment policies as well as the activities of the Navrongo Health Research Centre, are major components of the history of K-N West and have shaped understandings and practices of family planning. Local experiences of changing family formation cannot be understood without attending to larger political economic forces, a point that I unpack further in Chapter 3.

Chapter 3: Change and continuity in Kassena men's perceptions of family planning in northern Ghana

By: Lauren Wallace and Philip Adongo

This article was submitted in August 2016 to *Human Organization*.

Abstract

Studies suggest that men's perceptions of family planning in sub-Saharan Africa would be improved if they were included more extensively in family planning programs. However few studies capture how men's views change over time and what processes are responsible for these shifts. This follow-up study, framed by a political economy of fertility, highlights change and continuity in men's perceptions of family planning over two decades in Kassena-Nankana West District of the Upper East Region of Ghana, where a family planning program involving men was implemented in the 1990s. Eight months of ethnographic fieldwork was conducted in rural village and clinic settings in 2013 and 2014. We find that men's sense of responsibility for the cost of schooling, against a changing economic backdrop, as well as shifts toward "companionate marriage" are some of the most salient processes contributing to their growing approval of family planning. This study highlights the importance of paying attention to changes in the larger socioeconomic context that facilitate men's acceptance of family planning. We argue that programs incorporating men should move beyond health education to consider broader social and economic drivers of attitudinal change.

Keywords: West Africa; Ghana; Family Planning; Contraceptives; Men

Introduction

Sub-Saharan Africa has been characterized as a region more resistant to fertility decline than all other regions of the world. Fertility has declined steadily and rapidly in Latin America and Asia, but remains high in sub-Saharan Africa (4.7 births per woman per lifetime in 2010-15), more than double replacement level (UN 2015:3). Not surprisingly, the adoption of family planning on the continent has also been extremely slow. In sub-Saharan Africa, only 28 percent of married women of reproductive age use “modern contraceptives” like pills, injectables, IUDs or condoms, even though a very large proportion of women do not want to become pregnant soon or ever (UNFPA 2016:12). Since the 1994 International Conference on Population and Development’s (ICPD’s) twenty-year Programme of Action was published and ratified by 179 countries, research and policy initiatives have emphasized the importance of gender dynamics for improving sexual and reproductive health, including the uptake of family planning (Greene et al. 2006). The ICPD’s 20-year Programme of Action recommends that “efforts should be made to emphasize men’s shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning...” (UN 1994:27). The recently created framework of Actions Beyond 2014 reaffirms that the path to sustainable development and

reproductive health and rights requires the involvement of men (UN 2014:98).

Since the ICPD, many scholars suggest that the uptake of family planning in sub-Saharan Africa would accelerate if family planning programs brought men into the mainstream of their approach (Ezeh 1993; Bawah et al. 1999:64; Adongo et al. 2013; Greene et al. 2006; Hartmann et al. 2012:815) and a growing body of qualitative research has examined the impact of men on family planning (Bankole and Singh, 1998; Bawah et al. 1999; Chipeta, Chimwaza, and Kalilani-Phiri 2010; Onyango, Owoko and Oguttu 2010; Haartman et al. 2012; Adongo et al. 2013)

Men's disapproval of family planning is considered to be a barrier to contraceptive use among married women in sub-Saharan Africa. Men and women in this region often have very different views on desired family size (Ezeh 1993; Bankole and Singh 1998; Bawah et al. 1999:60) and husbands often want more children than their wives (Bankole and Singh 1998). According to Ezeh, men's attitudes toward fertility affect those of their wives, not vice versa (Ezeh 1993).

Men's views about family planning also have a strong indirect influence on women's contraceptive use (Adongo et al. 1997:1795; Biddlecom and Fapohunda 1998:360; Bawah et al. 1999:57). Men's disapproval of family planning acts to lower women's adoption of contraceptives through poor communication between couples about

reproductive goals (Chipeta, Chimwaza, and Kalilani-Phiri 2010:40).

Perceived spousal opposition is also a barrier to contraceptive use (Adongo et al. 1997:1795; Biddlecom and Fapohunda 1998:360; Bawah et al. 1999:57). Women in the Zambia, for instance, may avoid having conversations with their husbands about adopting family planning because they fear their spouse's negative reaction (Biddlecom and Fapohunda 1998:360). In contrast, joint communication between couples about family planning is associated with increased contraceptive use (Bawah 2002:185; Hartmann et al. 2012:802; Muntifering Cox et al. 2013:185).

Some scholars, however, question the limited focus on men as impediments to women's reproductive autonomy and health. They counter the normative concept of the dominant and hegemonic African man and leave open the possibility that many men may want to help their partners achieve better health (Barker, Ricardo, Nascimento, Olukoya, and Santos 2010:540).

Although relatively few family planning programs that incorporate men have been evaluated, research suggests that involving men may be a good strategy for improving contraceptive use (Piotrow et al. 1992; Shattuck et al. 2011; Adongo et al. 2013). Interventions targeting men have used different approaches, including counseling men on their communication skills, and educating them through local leaders and mass media campaigns (Shattuck et al. 2011; Adongo et al. 2013). The Malawi

Male Motivator project, for example, found that incorporating peer support into the program was effective at increasing women's contraceptive use by facilitating the ease and frequency of communication between couples (Shattuck et al. 2011). Adongo and colleagues also reported that in a program in southern Ghana which provided primary healthcare and delivery via home visits, men were more likely to be involved with family planning services (Adongo et al. 2013).

The literature on men and family planning is limited because men's perceptions have mainly been evaluated on the basis of static surveys or qualitative studies that track change over a short period of time (Piotrow et al. 1992; Sternberg and Hubley 2004; Barker et al. 2010:550; Shattuck et al. 2011). These studies fail to capture the shifting socio-cultural context that also informs men's views on family planning. In order to effectively design and evaluate family planning programs that incorporate men, we need to understand how men's perceptions change through time, and whether or not these changes are a direct result of public health initiatives. An ethnographic approach is ideal for conducting a broad investigation into sources of demographic change (Greenhalgh 1990:92)

In particular, anthropological approaches that adopt a political economy of fertility (PEF) are useful in that they contextualize the study of reproductive change within a larger analysis of the impact of history, economic, gender, culture and power (Greenhalgh 1990). The approach

draws on a historically-based analysis that often emerges from the narratives of living informants, “whose memories and historical data can piece together a coherent picture of change that illuminates the path by which fertility limitation spreads” (Greenhalgh 1990:92). This paper presents an ethnographic study conducted by one of us (Author One) over a period of eight months in 2013-2014 among the Kassena of northern Ghana where a high profile, innovative family planning program involving men was implemented in the 1990s (Phillips et al. 2012). Utilizing a political economy of fertility framework, we highlight change and continuity in perceptions of family planning among Kassena men that have occurred since the program was initiated. We show that a combination of program initiatives such as the reduction in child mortality and male mobilization in addition to socioeconomic changes, have changed men’s views. Ultimately, we argue that despite the positive emphasis on the involvement of men in family planning programs, broader drivers of change remain opaque.

Family Planning in Ghana

Ghana’s drop in fertility is regarded as a success story by demographers. Ghana currently has the lowest fertility rate in West Africa, and one of the lowest in sub-Saharan Africa. With a Total Fertility Rate (TFR) of four in 2008, Ghana achieved its fertility goal two years before

the target year of 2010 (GHS and GSS 2009:69). The downward trend in fertility is supported by married women's increasing use of contraceptives, which rose steadily from 13 to 24 percent between 1988 and 2008, marking the onset of irreversible fertility transition (GHS and GSS 2009:87).

Kassena-Nankana West and East Districts in the Upper East Region of northern Ghana, part of the Sahelian region of sub-Saharan Africa, have long been viewed as a challenging setting for family planning programs (Phillips et al. 2012). The barriers to introducing family planning in this context have been consistently depicted as the result of distinctive pronatalist features of African societies as described by Caldwell and Caldwell (Caldwell and Caldwell 1987). In the 1990s, communities were identified as geographically isolated and separated from urban centers and health facilities. Women and men perceived the concept of family planning to be economically threatening because large numbers of children were useful for agricultural and household labor and provided social security in old age (Adongo et al. 1997:1800). Most men and women practiced traditional religion; soothsaying and the importance of maintaining the ancestral lineage were believed to contribute to high fertility motives (Adongo et al. 1997:1796). Adongo and Bawah and colleagues also reported that men considered their wives' use of contraceptives as a threat to the existing gender order. Women who

practiced family planning were often perceived as promiscuous and physical violence was commonly accepted against wives who used family planning autonomously or refused sex (Adongo 1997:1795; Bawah et al. 1999:57,60). They argued that this anxiety reflected a patrilineal corporate family-kin system that involved the payment of bridewealth and led to the idea that women were the property of their husbands and the expectation that women should give birth steadily following marriage. Women's perspectives were reportedly subordinated to those of their husbands, soothsayers, lineage and compound heads; female literacy was low, further undermining women's autonomy (Adongo et al. 1997). Focus groups with women in the 1990s suggested that couples' communication about family planning was low; women wanted to reduce their fertility but that they were concerned about discussing the topic with their husbands or taking their own initiative to adopt contraception (Adongo et al. 1997:1795; Bawah et al. 1999:57). Researchers argued that misinformation about family planning, in particular the view that contraceptives can cause side effects that endanger women's health and fertility, reflected inadequate education about family planning in the district (Adongo et al. 1997:1799).

Consequently, a strategy was developed to involve male-decision makers and provide convenient, community-based services so that women could act on their reproductive preferences. In the 1990s, the

Kassena-Nankana district was the focus of a well-known study by the Navrongo Health Research Center that assessed the success of various strategies “to induce and sustain reproductive change in a traditional Sahelian cultural setting”, including the involvement of men (Phillips et al. 2012:176).

The initiative was designed as an action research project to test and develop a culturally-informed health and family planning program with the aim of decreasing the social costs of contraception and inducing a demographic transition. Since pronatalist perceptions were in part due to high child mortality, researchers introduced family planning as part of a broader primary health care program (Phillips et al., 2012). The program evolved into a national health policy known as Community-based Health Planning Services (CHPS) (Dalaba et al. 2016) that aimed to bring primary health and family planning activities from static, clinic-based locations to active doorstep care.

The project design involved interacting with men as community leaders and women as individuals, sensitizing male decision-makers, while providing convenient services so women could access contraceptives. Community health nurses were assigned to live and work in village locations, and community volunteers were given bicycles and trained to provide essential drugs, including condoms and birth control pills, and basic primary health care and referral services. Mechanisms

developed to motivate men to support or use contraception included working with authority figures such as chiefs, elders, and groups of men in durbars, meetings of male community members that involve dialoguing and information-sharing (Phillips et al. 2012).

Study Site

Kassena-Nankana West District is located in the Upper East Region, the second smallest region in Ghana. Both the rural communities involved in this study are Kassena. Families are predominantly small-scale peasant farmers, with farming complemented by retail and petty trading. Villages are arranged in extended family compounds of about seven regular residents, on average, comprising one or more nuclear families with a common male head. Descent among the Kassena is patrilineal and patrilocal. Polygamous marriages represent a minority of unions. Nearly all young men and women included in the 2013-2014 ethnographic study, as well as elderly and middle aged women, identify as Christian, while elderly and middle aged men commonly identify as traditionalists.

The villages are approximately 20 km from the closest major town, Navrongo and although they are not considered remote they are not electrified. The majority of people live in poverty. Locally, families are recognized as poor if the majority of adult members have little secondary or postsecondary education or regular source of income through wage

employment. Individuals in the current study are also considered to be poor by international standards, and subsist on less than \$0.16 per day (GSS 2008:107). Each community contains a community health compound and is no more than 5 km from the nearest health center.

Methods

Several methods were employed during the eight months of ethnographic research conducted by Author One among the Kassena. A local woman who worked at the Navrongo Health Research Center was hired to provide interpretation and translation services. Participant observation was undertaken throughout the study to better understand the realities of women's and families' lives. Direct observations of primary healthcare and family planning programming activities, such as shadowing outreaches, home visits and one-on-one counseling sessions, were made over a period of three months at two community-based clinics and one regional clinic.

Community members in two villages assisted in compiling 25 genealogies that encompassed 323 individuals. Genealogical information provided an invaluable snapshot of basic information about marriage, reproductive histories, and deaths. Genealogies also formed the basis for constructing 11 focus groups, comprising 7-12 participants each, which were conducted separately with men and women and organized according

to age and stage of family formation. Participants for focus group discussions were randomly selected to form groups based on their age, family size and socioeconomic status, and their willingness to engage in the discussion.

Fifty semi-structured interviews with equal numbers of women and men from different generations were conducted to investigate individual contraceptive use and ideas about fertility and ideal family size. Based on these interviews, 16 individuals from all stages of the life course and family formation, representing eight husband and wife couples, were selected for a more intensive investigation of life histories, in order to develop in depth case studies of married women's current use of family planning.

Participants for interviews were selected through quota sampling (Bernard 2011:144) and based on a set of pre-specified demographic characteristics, such as gender, family size, marital status and indicators of socioeconomic status, such as education. Given the private nature of conversations about contraceptive use, focus groups were conducted in the front yard of an unused compound, outside of earshot of other community members. Interviews were conducted in a location that was agreed to be comfortable for participants.

Interlocutors were given bars of soap for their participation. Participants in focus group were also provided with food. Study procedures were approved by the Navrongo Health Research Center's

Institutional Review Board and given clearance by McMaster University's Research Ethics Board. Author One and her research assistant were also given permission to work in the communities by local chiefs and sub-chiefs.

Study activities were recorded in English or the local language, Kasem, depending on participants' wishes. Focus groups were recorded and then transcribed and translated into English by the research assistant, while semi-structured interview and life history responses were translated into English on the spot and recorded verbatim. Focus group responses were translated after completion, since on the spot translation would have disrupted the flow of the group's discussion. All interview transcripts, field notes, and secondary data were coded in NVivo 10 by Author One and triangulated to reveal major themes and sub-themes.

Results

In order to portray the intergenerationally-patterned commonalities and uniqueness in older and younger men's perceptions of family planning, we provide two accounts of men's thoughts on family size and contraceptives. In November of 2013, seated in the hot afternoon sun in a field across from his family's compound, Author One had her first conversation with David about family planning. David, a young, college-educated man with one son is married to Kadua, a trader. Although his

wife, Kadua, told Author One in a separate interview, that she hopes to have as many children as they can afford, David stated that he wants a minimum of two children and a maximum of four, considering the expenses of taking care of children these days.

Kadua began using Depo Provera a few months earlier, after her husband suggested it. David was not home much for the past two years so the two were using abstinence until recently. While Kadua stated fairly freely that she uses family planning, David initially denied that his wife was using contraceptives, only admitting this in a follow-up interview a few months later. David was initially very reluctant to let his wife use family planning because of the side effects he heard about. He finally decided to let Kadua start family planning, realizing that if he didn't, his plan to have fewer children would not be realized. As he explained: "It seems like the injection has some side effects that is why I was afraid to use any of those things [contraceptives]. Because at times, some people will do it and they will complain...you know initially at first I said 'those things are not necessary', but when I realized that this plan is in my mind, then [we] have to do it to achieve our goal".

Joseph lives across the road from David in a large compound. He is a confident and charismatic sixty-five year-old man with seven children. Surrounded by his children and grandchildren Joseph described to Author One and her research assistant why he thought family planning should be

avoided and extolled the benefits of large families. Joseph explained that having small families put children at risk from childhood diseases like meningitis. He argued that men should strive for a large family, like his own, where all seven children went to school and became “big” people, since this would increase a father’s status and lead him to have an impressive funeral.

Joseph also vehemently articulated the negative effects family planning has on the behavior of women. He argued that wives adopted contraception without consulting their husbands, potentially causing marital discord and making it easier for women to have extra-marital affairs and young girls to become promiscuous.

When the family planning first came it was a good thing but now the way it has gotten it is no longer good. Why? Because if you allow your wife to do it she will... be flirting outside with other men. When the family planning first came, what they did then was that you and your wife will come to a compromise and then the two of you will go and you will do it and you are living happily with it...But these days when they [women] get there to the nurses, they will just pay and then do it and go without even telling the man. And aside that...If you send your child to school, she will not even go to school she will just take the family planning and be chasing outside, chasing men...

Joseph’s negative views about family planning were echoed in a few older men’s accounts; some were also concerned about the dangers family planning posed to economic and social security in light of the risks of childhood diseases, despite the fact that child mortality rates have

declined. However, most younger men shared more positive views of family planning; like David, they argued that family planning produced small families, which meant that parents were able to take care of their children and ensure their family's economic and social security. Unlike Joseph, who was a wealthy farmer, they did not have enough money to send all of their many children to school and reap the social and economic benefits of a large family.

Among young men, David's story was fairly typical. Most of the young men Author One interviewed favored family planning, because it would allow them to take care of their children, and to have sex without impregnating their wives; however, they remained suspicious of the impact of contraceptives on women's fertility and health. Unlike older men, most young men had positive views about the impact of family planning on marital relationships. Below, we expand on changes in men's views about the social and economic benefits of small families, and changes in marital relationships that have facilitated their increased acceptance of family planning.

Social and economic benefits of small families

Some older men remain reluctant to support family planning because they still perceive child mortality to be high, but younger people do not. During discussions at a community durbar to share results of this

research (March 2014), a young mother spoke out against an elderly soothsayer who was skeptical of family planning because of the risk of child death. Boldly disagreeing with his perspective, she expressed a positive view of family planning and pointed out the role of child immunization programs in declining family size. She shouted: “Today when you turn right and left and in front there are clinics. So you can give birth to two children and they will survive....” The crowd of community members at the durbar, many men, cheered and clapped when she finished speaking.

Intergenerational differences in men’s views of family planning are regarded by the younger generation as evidence of young peoples’ rationality and superior family formation strategies. Intergenerational differences in family size were described as part of myriad larger social and economic changes that distinguished the younger generation from their elders. Among these changes were increasing conversion to Christianity, nuclear family living arrangements, and awareness of the considerable costs of taking care of children, especially the importance of educating them.

For instance, when Abraham, a 24-year-old married man with nine siblings described his vision for his future family, he argued that he needed to be different than his parents since they are uneducated and did not properly consider the need to take care of their children. Expanding on

his description of his progressive, future family, Abraham also explained that he did not want to live with his parents, since they practiced traditional religion:

...You know, we Africans, we have traditional things and some of us [young people] believe those things should not be done. For example, [in extended family houses ...they will tell you, for instance that the soothsayer said they are to sacrifice a goat for this god...but we [the young generation] want the past to go so that we can embrace the future.

Although young Christian men such as Abraham still value extended kin networks they consider older men's views of family size to be impractical and often describe living in extended family units as problematic.

Young men frame family planning as a helpful strategy for taking care of children in light of changes in the rural economy. In particular, a positive view of family planning exists among Kassena men because it is necessary to limit family size in order to afford education for every child. A young father stressed this viewpoint in a focus group: "I think that family planning is very good and can help us to limit the number of children to be given birth to, hence enable us to take good care of our children, since it is very difficult these days to pay our children's school fees".

Young and old men's evaluations of the benefits of family planning frequently touched on the importance of education and the difficulty of paying school fees. While primary school and JSS (or middle school) are free in Ghana's public system, Secondary and Postsecondary education

are not. In addition, there are hidden costs for pencils, books, uniforms, parent-teacher association fees, and in some cases, unapproved registration fees. The advent of even more expensive private schools, which are viewed as offering better opportunities, are absorbing large numbers of schoolchildren in rural areas.

Men explained that educating children has become increasingly important in the face of declining agricultural yields that have diminished the usefulness of children's farm labor over the past decades. Due to climate change and land overuse, the hard work put into the land often yields a meager harvest and has produced growing poverty and nutritional insecurity. Author One observed that many families had eaten or sold the majority of their food by April, some five months before the next harvest, making it necessary to rely on purchased food. Under these circumstances, men and women emphasize that better work opportunities in the formal sector are available to educated children, which lead to higher family incomes and more substantial remittances for parents than farm work. Family planning is thus associated with economic security.

Improving gender equity in education has also contributed to the increasing costs of raising children, and the need for family planning. Educated girls, and the remittances from their formal work, have altered opinions about the value of women. Girls were once referred to by the Kassena as "bush things", since they marry out and only benefit their

husband's lineage; educating them was viewed as a waste of time. In contrast, families in the follow-up study were actively sending girls to school. The majority of men agreed it was important to send girls to school, since they can contribute equal or better remittances to their families than boys. In a comment typical of young fathers, Adam, a father of three in his early thirties, explained how ideas about gender have changed: "Now, it is not a matter of being a girl or a boy. Now everything has changed. If you have girls and the girl is in school, you can still sell whatever you will sell to take care of her knowing that wherever the girl is she will still remember to take care of people at home but in the past it wasn't like that..."

Large numbers of children are no longer associated with prestige and economic and social security. In fact, men noted that parents with large families produce "wayward" or "deviant" children: "bad boys" get involved in drinking, smoking and armed robbery; "bad girls" become promiscuous. These children bring shame to fathers and families.

According to Ada, a forty-year old man with one child and a community leader:

It [family planning] has helped a lot in the care of our families, because these days we have kids in moderation....If you can't take care of your family, then the kids get into bad habits. Some of them thieves, some of them troublesome, it brings a lot of heartaches.

Some young men, like David, and old men like Joseph – who argued that family planning led girls to spend their time chasing men rather than going to school – suggested that family planning has encouraged young girls to be promiscuous. In an interview with Ada, he expressed a similar view: “I think it has increased prostitution. Because they know that they [young women] will not give birth...They know that oh, if I have sex I won’t get pregnant so because of this reason let me have sex and then those [women] who have high sexual appetite prey on it because they know that”. Although outrage about “teenage pregnancy” and unmarried women using contraceptives was common, few young men argued that family planning would lead married women to become promiscuous.

Changes in perceptions of family planning and marital relationships

Young men’s changing perceptions of family planning are also articulated in terms of positive impacts on their marriages. Fathers emphasize how family planning not only enables parents to take care of their children, but also allows them to have sex without the fear that their wives will get pregnant. As a young father commented in a focus group: “It [family planning] is good because it helps us, the poor, to space and produce the number of children we would have in order to be able to take care them and also enjoy sex at the same time”. No men argued that

wives' use of family planning gave rise to domestic violence. Kojo, a father of four, argued that domestic abuse had declined because men's views of family planning had shifted: "In the previous years, people slapped their wives whenever they have discovered that they have gone to make family planning, but now they have stopped that because they realize it [family planning] is for their own help".

Men's positive perceptions of the use of family planning by married couples were conditional, however, depending on the context in which it took place. The lack of popularity of male condoms, and the abundance of female methods support the idea that family planning is something only done by women, an assertion that nurses often encounter while educating couples on home visits. Men are sometimes decried by their peers as a *kayolo* – a man-woman, or a man who is letting his wife control him – for going with their wives to the clinic to adopt family planning or to the market to buy foodstuffs.

Some Kassena men believe they should be the primary decision-makers regarding family size and that contraceptives should only be used with the husband's permission; however, this view was primarily held by young, unmarried men. The idea that married women are their husband's property persists. For example, in a focus group discussion, one man commented: "To me a woman cannot decide that way because if she can

do that she should remain in her father's house and begin giving birth, but as I am the one who brought her to my house, I have to decide that".

Most young married men who participated in the 2013-14 study felt strongly that family planning is a matter to be discussed between the husband and wife; doing so was an indication of a good marital relationship. Although young married men continue to disapprove of a woman who adopts family planning without consulting her husband, young men expressed the opinion that this occurs when a marriage is an unhappy one. The following exchange from an all-male focus group demonstrates these views:

Moderator: Can a woman decide on her own the number of children to give birth to?

R1: Yes, a woman can decide on her own and she can do anything at all without her husband's notice.

R2: It is not for a woman to take that decision without the husband's knowledge because it is good for the two of them to sit down and plan on the number children both will be happy of.

R3: If a woman decides to take that mantel decision then that means there no happiness in that marriage because it is good for husband and wife to sit together to plan about the number that they can take care of instead of the woman alone deciding on the number.

R4: Both of them are supposed to decide on that but the woman cannot do that provided she is married.

During Author One's life history sessions with men, ideal marriages were characterized by unity and understanding. Kassena men agreed that

a strong marriage was distinguished not only by the sharing of money, but by good communication. In describing why his relationship with Kadua was good, David stated: “The way she loves me and I love her also, the same thing. So there is nothing secret between us. This year her junior sister wrote the exam and she is supposed to go to SS and the parents didn’t even pay the fees for her. I rather went and paid the fees for her”. The majority of the young married men in this study described how they had discussed the need to adopt family planning with their wives. As Adam, a young father of three whose wife is using Depo-provera describes: “It was the two of us that sat down to discuss it [family planning]. Even when we first got married we both sat down and discussed it. We even did it [contraception] for a year and then stopped before she gave birth when we first got married. But it is the two of us that sat to take the decision”.

A similar pattern appeared in the responses of men to the question of whether a wife has the right to refuse sex. The idea that a wife is a husband’s property was expressed in focus group discussions, especially by youth. For example, a secondary school student argued: I married her so that we will give birth so she cannot refuse [sex]. However, most married men and youth considered the refusal of sex more appropriate if a woman has a valid reason for doing so; for example, if her husband upsets her, has HIV or is drunk, or if she is menstruating or sick. Young men

agreed that if a woman refuses to have sex with her husband he can try to convince her, but if that fails, he cannot force her because he could be arrested for rape.

The theme of family planning was common in discussions about how women's autonomy had changed. Many men argued that if a woman had given birth to the number of children she and her husband had planned she could refuse sex. Below is one typical comment from a middle-aged man in a focus group discussion:

...in the olden days, a woman can refuse sex if she is in menses and these days too, she can refuse her husband sex if she is menstruating. These days too, a woman can refuse her husband sex for them to space their children and be able to take proper care of them. A woman can also refuse her husband sex if the husband constantly has sex with her and she is not comfortable with it.

However, men argued that if a woman refused sex continuously without a valid reason, this was grounds for her husband to accuse her of cheating and divorce her, since wives were expected to have sex with their husbands:

R4:...A woman can refuse her husband sex when she is sick, tired or does not feel like having sex but cannot do that continuously...

R1: If she refuses, it can bring a fight between her and the husband and the husband can even sack her from the house.

Men's discussions suggest that although married women's use of contraceptives is less stigmatized today, women risk serious consequences if they do not fulfill their sexual obligations to their husbands.

Discussion and Conclusions

To our knowledge, this follow-up study is one of the first in sub-Saharan Africa to examine men's perceptions of family planning over multiple decades. One limitation of this study is that data quality was reduced because interviews with men were conducted by a female researcher. A tacit, long-held assumption by researchers is that participants are more likely to provide accurate information on sexual behavior to interviewers of the same gender. However there is little research confirming this view. A recent study on the sexual and reproductive health responses of young men in Ghana suggests that there is no interviewer gender effect (Agula, Barrett and Tobi 2015).

In the 1990s, Adongo reported that men in northern Ghana were reluctant to adopt family planning because they perceived it to be economically and socially threatening. Child mortality rates were high and large numbers of children were important for agricultural and household labor and provided social security in old age (Adongo et al. 1997:1800). Men also worried that wives who used contraceptives would be unfaithful

and argued that reproductive decision-making was the prerogative of husbands. Spousal non-communication, and women's fear of their husband's reprisals, was common.

We find that men's acceptance of family planning has increased considerably in Kassena-Nankana West since baselines studies in the 1990s (Adongo et al. 1997; Bawah et al. 1999). Men's discussions of family planning, which are situated within considerations of broader political economic shifts, suggest that ideas about responsible manhood have shifted, and are now linked to the production of small, well-cared for families.

Despite Kassena men's favourable views of family planning, anxieties about the risks of side effects for women's health and fertility remain. Men continue to worry about not being able to control women's bodies. Although husbands are less anxious that married women who use contraceptives will become promiscuous, unmarried women's use of contraceptives is stigmatized and linked with ideas about uncontrolled sexuality. Men claim that a woman's use of family planning is no longer met with threats of violence; however, gendered scripts still make women obligated to fulfill their sexual obligations to their husbands, or else they run the risk of divorce.

While the idea that men need to be able to control female sexuality persists, it does not appear to be the barrier to contraceptive use that it

once was. One of the most significant social changes is men's focus on the importance of spousal communication about family planning. This suggests that husband-wife relationships have shifted towards "companionate marriage" (Smith 2007). In his discussion of companionate marriage among the Igbo in Southeastern Nigeria, anthropologist Smith argues that changes in marital relationships are "most pronounced in narratives about courtship, in the way husbands and wives describe how they resolve marital quarrels and in the way they make decisions about and contribute to their children's education" (Smith 2007:999). Smith argues that while ideas about marriage still draw on "enduring traditional scripts" which support male power, in private assessments about the state of their relationship, the quality of a couple's marriage is more likely to be measured based on the degree of emotional intimacy. The Kassena findings draw parallels to Smith's discussion; despite some enduring ideas of male dominance, husbands increasingly associate decision-making about family size, and in turn, positive marital relationships, with "conjugal affection and compromise rather than male authority" (Renne 1993:350).

Analyses often focus on the direct link between spousal communication and contraceptive use (Bawah 2002:185; Hartmann et al. 2012:802; Muntifering Cox et al. 2013:185), but this ethnographic investigation suggests that increased communication between spouses and family planning occurs in a larger context of changing marital

relationships. A decline in polygyny may have fostered companionate marriages in Kassena-Nankana West. Polygyny has long been considered an important mediator of spousal relationships in sub-Saharan Africa, impeding discussion about reproduction and spousal trust by separating mother-offspring units into their own economic and residential arrangements (Caldwell and Caldwell 1987:420; Adongo et al., 1997:1794).

Even though some Kassena men continue to have “outside wives”, the practice of formal polygyny has declined considerably, owing to the popularity of Christianity, the cost of raising and educating a large family, increased economic hardship, and rivalry between wives. Doctor and colleagues estimate that in 1995, 45 percent of women aged 15-49 were in polygamous relationships (Doctor, Phillips and Sakeah, 2009:117). However, in 2013-2014 in the communities surveyed for this study, only 20 percent of married women aged 15-49 had co-wives.

While reproductive research has focused on program strategies to reduce men’s negative perceptions of contraceptive use and increase spousal communication, (Piotrow et al. 1992; Shattuck et al. 2011; Adongo et al. 2013) the political economy of fertility framework employed in this follow-up study highlights the importance of paying attention to changes in the larger socioeconomic context that facilitate men’s increasing acceptance of family planning. Scholars working in sub-Saharan Africa

have shown that program messages focused on the economic benefits of limiting births are a useful entry point for engaging men in reproductive change (Renne 1993:351; Withers et al. 2015:210; Dalaba et al. 2016:6). However, we argue that these points of entry for family planning programs are also supported by contextual social and economic processes that are intergenerationally-patterned. In order for men to become a positive force in family planning efforts, they must see the benefits of limiting children, such as economic improvement for their families.

The analysis of the impact of the health and family planning program on men's perceptions in northern Ghana is complicated by the fact that the social changes that supported men's shifting views were already underway in the 1990s, when the health and family planning program was introduced. In 1997, baseline panel surveys suggested that some men and women were already beginning to associate fertility decline with larger economic and social changes, such as the costs of children's education, and the diminishing availability of fertile land and environmental changes, and were seeing family planning as a means of adapting to these processes (Adongo et al. 1997:1802-1803). We suggest that a combination of program strategies, including the reduction of child mortality and male mobilization, in addition to socioeconomic changes, such as the increasing importance of child education, mitigated initial negative views about family planning.

Dalaba and colleagues recommend that to increase contraceptive use and facilitate reproductive health in northern Ghana, the health and family planning program should scale up the engagement of men in groups (Dalaba et al. 2016:6). Program evaluations show that group education sessions with men of all ages are useful, especially when integrated with other approaches such as community outreach (Barker et al. 2010:550). Door-to door education sessions, which are already used by the CHPS are useful in disseminating family planning knowledge to men, since they create a private platform for men to ask questions and dispel rumors (Adongo et al. 2013:13). These types of sessions also apply a life-course approach to health promotion in that they can be tailored to men of different ages and opinions within the same household, and have the added advantage of delivering family planning education while addressing other health concerns.

However, typical policy recommendations, which focus primarily on educating and sensitizing men to increase the use of contraceptives, are problematic in that they often are not articulated within the broader, multi-sectoral agenda of the ICPD. For example, the reasoning used to promote men's involvement in the Navrongo program demonstrates an enduring concern with reducing fertility rather than expanding individual rights in sexuality and reproduction. Programs incorporating men should move beyond health education to identify more proximal influences on gender

equity, also termed “social rights”, or enabling conditions, such as economic security (Greene 2006:7). In doing so, family planning programs would align their strategies with a broader agenda that reconfigures existing social determinants to facilitate gender norms and values that support gender equality and health.

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Chapter 4: Making Modern Families: Family Planning and Biocitizenship in Northern Ghana

By: Lauren Wallace

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Abstract

This paper examines emerging discourses of family planning and biocitizenship in northern Ghana. I draw on 8 months of ethnographic research undertaken between 2013 and 2014 with 25 families and 6 health workers in Kassena-Nankana West district of the Upper East Region of Ghana, where fertility has recently declined. I show that family planning is not simply a matter of reproductive control, but is connected to a process in which new idealized bodies, forms of parenthood and families are created and linked to good citizenship. Young men and women strategically deploy “reproductive rights and wrongs” discursively to present themselves as good parents and citizens in the context of shifting economic obligations, and family relationships. Biocitizenship discourses are intergenerationally-patterned and gendered and work through the docile bodies of health workers to impose stronger effects on some citizens than others. I suggest that evolving discourses of biocitizenship are not merely abstract representations, but impact men and women in very real ways through the neo-Malthusian understandings of underdevelopment they engender.

Keywords: biocitizenship, biological citizenship, family planning, family size, West Africa, Ghana

Introduction

When I asked an elderly grandmother, Kada, who gave birth to ten children, why Kassena people no longer have many children, she suggested that it was because people are now “enlightened.” She said “we are now wiser than in the past; that is why we give birth to fewer children. We know that giving birth to fewer children means that you can educate your children and take care of them. But when we [the older generation] were giving birth, we didn’t know anything because we were naïve.” In my discussions with Gifty, a twenty-one year old secondary school graduate, she explained that young women like herself wanted no more than three or four children, because:

...this is modern Ghana, and almost all of us [young people] are educated. If you are educated and you give birth to children that you cannot take care of, then what is the purpose of your education? It means you are an illiterate...

The modernization and neo-Malthusian¹⁴ discourses that depict large families as backwards and smaller families as progressive have infiltrated both health workers’ and Kassena citizens’ descriptions of

¹⁴ Neo-malthusianists maintain that population control programs are important to ensure resources for current and future populations. Like Thomas Malthus (1926), they maintain that population growth will outstrip the earth’s carrying capacity – the number of people that the earth can support without starvation or environmental degradation.

themselves and others. This paper describes the role of family planning and declining family size in producing new discourses of biocitizenship in northern Ghana. Following Rose and Novas, I see biocitizenship as “citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings as individuals, as families, and lineages, as communities, as population and races, and as a species” (Rose & Novas, 2008, p. 440). Biocitizenship consists of a set of practices or behaviours that change how citizens shape their life course in terms of specific biological images in order to become rational, prudent citizens. Biocitizenship is both individualizing and collectivizing, in that it inspires individual and group change in line with biosociality¹⁵ (Rose & Novas, 2008, p. 441). What’s more, it operates within “political economies of hope”, which tie together personal biographies and aspirations and “comprise[s] a domain of possibility, anticipation and expectation that requires action and awareness of the present in order to realize a range of potential futures” (Rose & Novas, 2008, p. 452). Explanations of biocitizenship go beyond considerations of the impact of powers from

¹⁵ Biosociality is the formation of social relationships and identity based on the biological condition (Rabinow, 1996).

above, such as the state, on docile bodies¹⁶ to describe how citizens relate to themselves and others.

Some scholars have linked biosociality with global governance structures, state institutions, and gendered relationships and have considered the ways some citizens are celebrated at the expense of others (Briggs & Mantini-Briggs, 2003; Nguyen, 2008; Petryna, 2006; Greenhalgh and Carney, 2014; Benton, 2015). While I consider the ways in which the rhetoric of biocitizenship is stigmatizing and gendered, the Kassena narratives illuminate the relationship between biocitizenship and intergenerational relationships. First, I describe the shifting political economic context that has made smaller families an indicator of good biocitizenship and has stigmatized larger families. I show how biocitizenship projects impose stronger effects on some people, particularly men and older community members, and operate through “political economies of hope”. Finally, I compare ideas about family

¹⁶ The notion of the docile body focuses on the body as an object and target of power. Bodies are docile in that they are subjected to institutional regulation and may be used to maintain discipline (Foucault, 1975).

planning held by health workers and community members to consider the way biocitizenship operates through docile bodies. I argue that evolving discourses of biocitizenship are not merely abstract representations, but impact men and women in very real ways through the neo-Malthusian understandings of underdevelopment they engender.

Family Planning in Ghana

I conducted ethnographic research in northern Ghana in 2013 and 2014. Ghana currently has the lowest fertility rate in West Africa, (4.2) and one of the lowest in sub-Saharan Africa. Knowledge of contraceptive use is almost universal, with 99% of women having heard of at least one family planning method. Nationally, twenty-nine percent of women use contraceptives (GHS & GSS, 2015).

Ghana's National Population Policy and Strategic Plan for Reproductive Health promotes family planning as an important strategy for poverty reduction, economic development, gender equality and improved maternal and child health (GHS, 2007). Like reproductive health policies elsewhere in sub-Saharan Africa (c.f. Richey, 2008), the rhetoric of Ghana's reproductive health policy reproduces the values and assumptions of global population discourses (see for example, USAID¹⁷,

¹⁷ United States Agency for International Development

2015; UNFPA¹⁸, 2006). While the government of Ghana adopted the 1994 Cairo Conference recommendation to emphasize reproductive rights rather than fertility control, promotional materials for family planning remain wedded to reducing fertility, and subscribe to neo-Malthusian ideas about development. For example, the campaign's family planning flipchart for educational sessions emphasizes that contraceptives allow "couples/partners [to] plan better for their children's needs – food, clothing and education...and can help the community have more adequate resources such as schools, clinics, water supply, food and recreational centres" (GHS & BCS, 2010, p. 2). These discourses have been adopted uncritically by citizens and health workers.

Study Site and Methods

I spent eight months conducting ethnographic research on perceptions of family size and family planning in Kassena-Nankana West District (K-N West) in the Upper East region of northern Ghana. K-N West is located in the Sahelian region of sub-Saharan Africa, a region characterized as particularly resistant to fertility decline and contraceptive use (Caldwell & Caldwell, 1987; Phillips et al., 2012) and where in the 1980s and 1990s fertility regulation focused on spacing children, rather than on limiting family size (Caldwell & Caldwell, 1987; Adongo et al.,

¹⁸ United Nations Population Fund

1997). K-N West, however, has been the site of widespread change in reproductive practices over the past few decades, prompting researchers to examine the influence of primary healthcare and family planning programs on declining family size and increasing contraceptive use (Phillips et al., 2012). Here I explore how changes in family formation are also linked to ideas about biocitizenship.

I conducted research in two Kassena communities, comprised of approximately 1500 and 1220 people respectively, made up of predominantly small-scale peasant farmers who supplement their incomes with retail and petty trading. These communities are considered impoverished by international standards, with villagers subsisting on less than 0.16 USD per day (GSS, 2008). They are arranged in extended family compounds of about seven regular residents, comprising one or more nuclear families with a common male head. Descent is patrilineal and patrilocal. Polygamous unions represent a minority of unions. Nearly all the interlocutors in this study identify themselves as Christian; however, elderly and middle aged men commonly identify as traditionalists.

Each community in this study has a community health compound and is within five km of a regional health centre. Regional health centres and community health compounds provide one on one counselling to women and family planning education is provided by nurses during child welfare clinics as well as through a home visiting program; family planning

education is delivered as part of a broader community-based primary healthcare program. The program has been effective (Phillips et al., 2012). Between 1988 and 2008, the Total Fertility Rate (TFR) in the Upper East Region declined from 6.6 to 4.1, while “modern”¹⁹ contraceptive use increased from 0.7% to 14.7% (GHS & GSS, 1999; GHS & GSS, 2009). Various types of contraceptives (such as contraceptive injections and implants, birth control pills, condoms and emergency contraception) are available at district and regional hospitals, health clinics, community health compounds and through the private sector.

During my eight months of ethnographic research in Kassena-Nankana West, I used a variety of methods to engage people in conversation about their ideas about family formation, including participant observation in communities and direct observation of six nurses’ family planning activities at a regional clinic and two community health compounds. I collected twenty-five genealogies that encompassed 323 individuals, conducted focus groups, interviews and recorded life histories. The genealogies contained invaluable information and formed the basis for constructing eleven focus groups, comprising 7-12 participants each, which were conducted separately with men and women and organized according to age and stage of family formation. Focus group participants

¹⁹ Excludes abstinence, rhythm and withdrawal.

were randomly selected to form groups based on their age, family size and socioeconomic status, and their willingness to engage in discussion.

I conducted fifty semi-structured interviews with equal numbers of women and men from different generations. Participants for interviews were selected through quota sampling based on a set of pre-specified demographic characteristics, such as gender, family size, marital status and indicators of socioeconomic status, such as education. Sixteen individuals (eight husband and wife couples) from all stages of the life course and family formation, representing a variety of demographic characteristics, were invited to participate in a deeper investigation of life histories. A local woman who worked at the Navrongo Health Research Centre was hired to provide interpretation and translation services.

Modernizing the Kassena Family

The world has changed” is a common cliché repeated in Kassena-Nankana West. Men and women argue that the old days were simple, while modern life is complex with many requirements, needs and necessities. Despite concerns about the physical side effects of contraceptives (Adongo et al., 2014; Wallace & Adongo, 2016), men’s and women’s discussions frame family planning as a necessary strategy in order to take care of children in light of changes in the rural economy that

have made children expensive. Three quarters of the married couples in my study used contraceptives for these reasons²⁰.

Describing why it is a responsible decision to have fewer children, Christie, a twenty-four year-old mother of two, explained:

The system today is very hard, the economy is hard. First due to the importance of educating your children, when you have many children there will be school fees that you cannot even pay, even managing to feed them will be a major problem. Because for instance, if the family does not get a good harvest, who will take care of their children?...

Farming life in Kassena-Nankana West has always been surrounded by uncertainty. Missionary reports written sixty years ago indicate that there is little potential wealth in the land “and what it [the land] does possess it yields to the individual only with the most painstaking labor” (Howell, 1997, p. 46). Climate change has produced erratic rainfall and shortened the growing season. In addition, continual grass burning and land overuse have decreased its fertility, making it necessary for the Kassena to

²⁰ Data to calculate how total fertility rates in my sample have changed are not available. The percent of married women who used contraceptives is three times higher than survey estimates. Rates of contraceptive use based on ethnographic research are expected to be more accurate than survey-based estimates since multiple interactions with informants increase rapport and provide more opportunities for cross-checking information (see Bleek, 1987).

increasingly rely on purchased food. Declining agricultural yields have diminished the usefulness of children's farm labour, supporting the rationale for children's education and small families. Kassena men and women regard family planning positively because they believe it is necessary to limit births in order to afford secondary and postsecondary education for each child, which are coupled with hidden and indirect costs for school supplies, nutritional food and better clothing. A small family also allows parents to provide children with a "proper upbringing" that requires material and social investments. Participants frequently repeated that children today are not like children of the past: modern children have greater needs and expectations.

Schools are a primary site for constructing modernity in Ghana (c.f. Coe, 2005). Young parents emphasized that it is important to receive a *quality* education in order to secure a good job and that private schools provide the best opportunities for jobs in the formal sector. A burgeoning market for private schools, including preschools, has recently emerged in northern Ghana. Private schools absorb an increasingly large number of rural school children, burdening their parents with additional expenses and further underscoring the importance of smaller families.

Well-educated children, moreover, contribute to their parents' survival and wellbeing; they have the potential to gain jobs in the formal sector that bring the promise of remittances to support parents. Recently,

well-off children have begun to provide expensive cement bricks and iron sheet roofs to build rectangular blockhouses in parental compounds. Blockhouses are more durable than traditional mud compounds and signify parental wealth and children's status and accomplishments (c.f. Cassiman, 2008). My conversation with David, a young father, who wants only two or four children and encouraged his wife to adopt family planning, demonstrates the importance of modern assets like blockhouses for ideal family-making. When David was asked to draw a picture of his ideal future family, he drew a picture of a large cement house with a kitchen, a toilet, separate rooms for visitors and a room with computers where his children could study.

However, such grand houses are few and far between in Kassena-Nankana West. Although men and women act as good biocitizens, and hope that small families will lead them to economic success, several families' experiences of socioeconomic deprivation provide evidence to the contrary. For instance, as Kojo, a young father of four, revealed to me in his life history, despite his small family, and his hardworking nature, life is not easy. He and his wife Mary have no formal employment besides farming.

Kojo can barely farm his seven acres of land because of the cost of fertilizer and plowing. His inability to properly prepare much of his land this year resulted in a poor yield. As of April, with six months left until the next

harvest, the family's food was finished and Kojo was forced to sell some of his animals to buy food. Although Kojo and Mary have been able to scrape together money to send their children to school, they are not sure what the future holds. When asked about his hopes and dreams for the future, Kojo stated: "I hope that I should be able to take care of the children. At least to finish school and be better off than the way I am. But because I am poor right now it won't be easy at all." Kojo confessed that he and Mary are using abstinence since they do not plan to have any more children because of their economic situation. Among the Kassena, family planning creates a "political economy of hope" (Rose & Novas, 2008, p. 452), in which the potential economic benefits of smaller families depreciate worry in the face of an uncertain future.

Fertile Deviants

Despite the fact that small families do not always ensure economic security, ideas about the superiority of parents who have fewer children endure. Although the rhetoric of biocitizenship idealizes smaller families, parents are more concerned about their ability to take care of their children than the number of children they have. Rational, modern, "enlightened" people are aware of the costs of taking care of children, especially the importance of children's education. People who do not subscribe to this view are regarded as lesser citizens. Knowledge about the importance of

contraceptives for limiting family size is considered to be a badge of education. Thompson, a grandfather, explained how education impacts community members' acceptance of family planning: "[t]oday education has come. We are enlightened. If you are not enlightened, how will you ever think of sending your children to school or limiting the number of children you have to two or three?" The link between education and family planning is made despite the fact that many of the women and men who adopt family planning are not well educated.

Kassena men and women increasingly distinguish themselves from others by "looking askance at other people's children" (Schneider & Schneider, 1996). The new economic rationality considers parents who fail to embrace family planning as burdening their family and community by producing children who are inferior citizens. Having children that one cannot take care of is considered to undermine a family's economic and social security in a social climate where poverty is rampant. Larger families are thought to produce "wayward children" who, because they cannot be cared for properly, fail to make meaningful contributions to their communities and, worse, engage in "social vices" such as armed robbery, teenage pregnancy and substance abuse, particularly alcoholism and "wee" (marijuana) smoking.

There also appears to be little sympathy if large families find themselves in economic distress. As Ransford, a middle-aged pastor with

four children, noted “those people that say the economy is worse, maybe they are not ready to take family planning seriously to help themselves.”

Similarly, Gifty, a twenty-one year old secondary school graduate, argued,

[if you give birth to many children and you cannot take care of them] no one is ready to take care of any child who is not his blood. So I would not like to give birth to the number that my mother gave birth to....some people will take pity on you, but some will not even look at you or care that you are suffering with your children because there is family planning and it is not costly to use.

The circulation of children through child fostering has always operated as a traditional welfare system in northern Ghana (c.f. Cassiman, 2008). A Kassena proverb: “children are for everyone”, captures the traditional view that children are reared by many people in the community, not just biological parents and relatives. While Gifty and others emphasized the value of looking after someone else’s child, they acknowledged that the poverty level and costs of children’s education made doing so increasingly difficult and unattractive, supporting a focus on family planning in order to take care of one’s biological children.

Gender, Age and Family Planning

Links made between family planning, gender and age in northern Ghana illuminate how biocitizenship projects impose stronger effects on some biocitizens than others. Men are held disproportionately responsible for enacting poor citizenship. In focus group discussions, young women lamented that husbands often did not take care of their wives or children or understand the benefits of family planning; therefore, wives were forced to have more children than they could take care of or had to adopt contraception covertly. The following comments are typical complaints from young mothers about the bad behaviour of men:

When the women say you give birth to 2 or 3 and you go in for family planning to prevent children, your husband may not understand and this brings about quarrels in the house. Because of that, the woman will not go in for that [family planning] again and this makes them give birth to many.

The reason [women give birth to fewer children today is because] there are school fees, food, health insurance to take care of and because the man may be a drunk and the burden will now sit on you...

Exchanges between young mothers demonstrate that most married women feel that they are more reproductively responsible than men and

cited examples of men who spent their money on alcohol or concubines or wanted to have more children than his wife could care for.

Among the Kassena, ideas about biocitizenship and family planning exaggerate gendered realities. Although in focus groups women discussed men's irresponsibility in the family planning domain more generally, the depiction of men as a significant barrier to contraception downplays the reality that many men, especially young men, encourage their wives to adopt contraceptives. The majority of couples I interviewed (separately) had jointly discussed the need to adopt family planning. In over half of the cases, the husband initiated the conversation (Wallace & Adongo, 2016).

There are also clear generational differences in attitudes toward smaller families. Young people's discussions clearly demarcate the younger generation as better biocitizens than their parents or grandparents. In describing the benefits of family planning, young women and men repeatedly lament that their parents, most of whom are uneducated farmers, failed to have the foresight to plan their families in order to provide their children with higher education. As a result, they were led into a life of poverty and hardship. While describing his vision for his future family, Abraham, a 24-year old unmarried man with nine siblings, reflected on how the negligence of his parents shaped his views on ideal fatherhood

...In fact they never even thought of sending us to school...because of that I just decided to start school on my own... I want to prioritize my children to make sure that they get the best in life... I plan to be better than my parents...those days, once they start giving birth they don't know even how to stop giving birth...But now there is advancement in society so people now know birth control.

Since Abraham's parents were not sufficiently diligent to prioritize the needs of their children, he was forced to fund his education. He plans to have only four children to ensure that he can care for each of them properly. Young men and women such as Abraham often used phrases like "our generation" to explain how they want their lives to be; they also identify collectively in accordance with biological images of smaller families. Intergenerationally-patterned ideas about biocitizenship and family planning also operate within "political economies of hope" (Rose & Novas, 2008, p. 452) in which the younger generation's access to knowledge about the benefits of having fewer children and using contraceptives have engendered hope for a more successful future than the previous generation.

While some young Kassena men and women consider young parents, especially fathers of large families, as inferior citizens who should not be pitied, elderly parents do not occupy the same low status. They acknowledged that their parents were socialized within a different set of

gendered and economic circumstances; their parents' childbearing years occurred during a time when the importance of educating children was not understood and contraceptives were not readily available. Abraham captured this sentiment as follows: "They just thought of giving birth to children. I mean I don't blame them. The insight, just having that knowledge, taking care of the children is a problem."

Members of the older generation also depict themselves as naïve about children's needs and family planning and now "hav[ing] their eyes opened." However, they collectively identify with an anti-modernist, less dominant counter discourse through the claim that family planning contributes to female promiscuity. Some older men, like Joseph, think that wives' use of family planning could encourage them to have affairs:

When the family planning first came it was a good thing, but this is not the case anymore. Why? Because if you allow your wife to do it she will grow rubber horns and leave you inside the house to flirt outside with other men... It has spoiled the young girls. If you send your child to school she will just take family planning and be chasing other men.

A more common complaint among older men and women is the link between family planning and promiscuity among young unmarried women. They note that schooling, churchgoing, and the decline in female

circumcision have led to increased mobility for young women and changes in courtship norms. This means that parents are less involved in the traditional marriage process than in the past, a phenomenon observed by anthropologists in other sub-Saharan African settings (c.f. Bledsoe & Cohen, 1993). Members of the older generation attribute changes in courtship norms and bridewealth negotiations to increasing disobedience and participation in uncurbed and unsanctioned sex among young people; for some, the introduction of family planning has facilitated these processes.

Parents and elders in northern Ghana describe the changes in the sexual behavior of young people within a larger context in which the disobedience of children has increased (c.f. Mensch, Bagah, Clark & Binka, 1999). Paradoxically, although most elders value the increasing education levels of children, they frequently locate the causes for children's changed behavior in processes of modernization, including higher education levels and the introduction of money into what was, until recently, largely a subsistence economy. Many elders feel education is a double-edged sword. Although it has resulted in higher remittances and has "opened" people's eyes", it has also undermined traditional family values, including traditional ways of disciplining children, causing children to lose respect for their parents. For example, a common complaint among elders is that food deprivation or corporal punishment was used in the past

as a way of disciplining children; now, children's integration into the modern economy and campaigns for child rights have rendered traditional disciplinary techniques morally unacceptable and ineffective. In contrast, most young people I spoke to saw no downside to education and viewed the move away from "old world" traditional values, particularly extended family living arrangements and traditional religion, as positive. Clearly, perceptions of biocitizenship and family planning are not homogeneous or static. Multiple biocitizenship discourses coexist among the Kassena, which are intergenerationally-patterned.

Health Workers' Views

Nurses discussions of family planning and direct observation of their activities reaffirms Kassena citizens' ideas about biocitizenship and demonstrates how it operates through the docile bodies of health workers. Like community members, nurses also considered men's irresponsible nature to be one of the most significant cultural barriers to family planning. While community members tend to discuss the benefits of family planning for individuals and families, nurses emphasized its benefits for Ghanaian society, especially for communities in poor areas. Christie, a young nurse working at the regional health center's family planning clinic, commented that if the population was too large, it would be difficult for children to get a quality education, since large families resulted in overcrowded schools. In

this way, nurses' descriptions of family planning subscribed to neo-Malthusian ideas about development, in which lower fertility rates are a solution for the mismatch between resources and population.

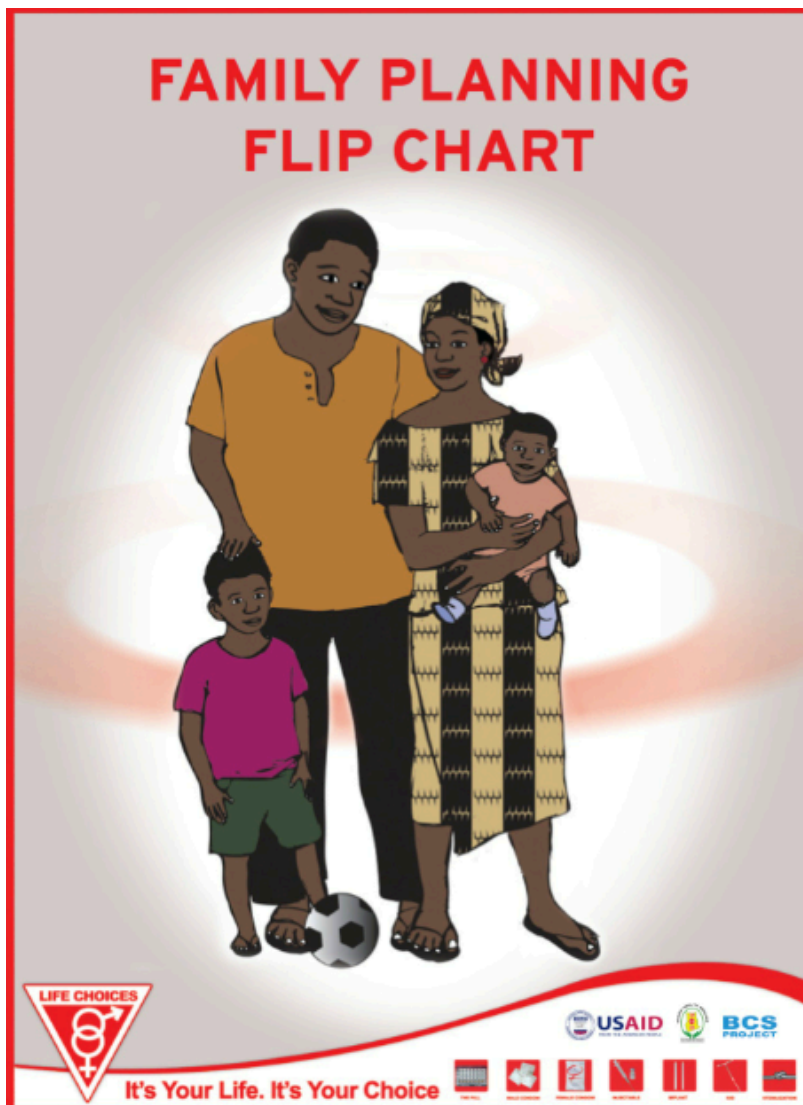
Nurses determined which families to target for family planning education through home visits by using the characteristics of good biocitizenship as a marker. Ideally, nurses should spend equal time between each home providing basic health education and services. However, in order to navigate the often large distances between houses, nurses require working motorbikes, fuel, and time, which are often scarce. I observed that due to the lack of time and resources, some nurses primarily targeted for family planning education households considered unable to care adequately for their children. Nurses assessed families' living conditions, including the state of children's clothing and health insurance, the frequency with which children are fed and whether or not school fees are being paid; those deemed to be bad biocitizens were more likely to receive family planning education than those who were not.

Discussion and Conclusion

In northern Ghana, young people's desires for a small number of well-fed and educated children reared in nuclear family settings are linked to shifts in the social and economic landscape and their hope for a more successful life than that of their parents. The attitudes of young people are

reflected in the Life Choices campaign image (see Figure 1) of an African family with two nicely dressed, well-spaced children with a soccer ball. Here, ambition, economic success and family planning are logically connected.

Figure 1: Front Cover of the Life Choices Flip Chart (GHS & BCS, 2010)



Similar to national and international rhetoric, citizens' localized understandings of the benefits of smaller families also consider family planning as important for poverty reduction. Despite evidence that fertility decline has not led to widespread poverty reduction in K-N West, health workers emphasize the drain high fertility places on local infrastructure, and men and women mobilize neo-Malthusian rhetoric to link large families to household poverty and bad citizenship through "social vices." Local interpretations of biocitizenship and family planning incorporate a modernization perspective that facilitates victim-blaming. Men and women blame impoverished individuals for their lack of education and irresponsible parenting strategies, while some health workers target bad biocitizens in home visits, rather than focusing on all households equally.

Biocitizenship and family planning rhetoric among community members and health workers is gendered in unique ways. Distinctions between irresponsible men, who are ignorant about family planning and their wives' and children's needs, and responsible women, who bear both childrearing and family planning, are often made by both nurses and their clients. While biocitizenship can reflect gendered realities, the current study suggests that they may also exaggerate them (c.f. Greenhalgh, 2014; Benton, 2015). The depiction of men as a significant barrier to contraceptive use downplays the reality that many men encourage their

wives to adopt contraceptives and that resources to engage men in family planning are not always available.

Previous considerations of biocitizenship have linked biosociality with gendered relationships and stigmatization (Greenhalgh and Carney, 2014; Benton, 2015; Briggs & Mantini-Briggs, 2003), however, stories from Kassena-Nankana West illustrate the importance intergenerational relationships play in the construction of the “political economies of hope” necessary for biocitizenship (Rose & Novas, 2008, p. 451). Building on Rapp’s (2000) concept of “moral pioneers” Rose and Novas (2008) argue that activist communities forming on the Internet and elsewhere in response to disease threats are “ethical pioneers” who are creating new, biomedically-informed techniques to manage everyday life (Rose & Novas, 2008, p. 451). Similarly, in northern Ghana, the younger generation act as “ethical pioneers.” Their relatively higher educational status and early acceptance of the biomedical rationale of family planning, compared to their elders, serves as evidence of their rationality.

Other studies of citizenship and family planning suggest that bad biocitizens are those who have limited education and knowledge about family planning (DeZordo, 2012). However, although some young Kassena men and women consider their uneducated parents, especially fathers of large families, as inferior citizens who should not be pitied, elderly parents do not occupy the same low status. It is understood that

they were socialized at a time when the importance of educating children was not understood and contraceptives were not readily available.

Perhaps most salient are the ways in which biocitizenship impacts men and women visibly by making certain kinds of ethical demands possible, and others unachievable (Rose & Novas, 2008). In this account of family planning among the Kassena, national policies and on-the-ground rhetoric incorporate neo-Malthusian and modernization discourses which link a lack of resources for development and family size, blaming citizens for poverty levels. These public health discourses miss the mark in that they fail to address the unequal distribution of wealth and power. As we search for more effective ways to improve family planning programs, we also need to address the practice of blaming communities for underdevelopment.

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Chapter 5: “It doesn’t match my blood”: Concerns about contraceptive side effects among Kassena women in northern Ghana

By: Lauren Wallace

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Abstract

Concern about side effects is one of the most commonly cited reasons for women’s non-use of contraceptives in sub-Saharan Africa, and the most common reason why women discontinue family planning. While studies find that some of women’s worries about contraceptives are based on distressing side effects, such as menstrual disruption, nausea, weight gain and delays in fertility, researchers frequently focus on misinformation spread by rumour. These studies decontextualize women’s concerns from the larger gendered context of their lives. Drawing on ethnographic field research carried out in northern Ghana, this paper examines women’s concerns about side effects, and the impact of these concerns on family planning practice. I show that despite anxiety about side effects, and their real physical, social and economic consequences, some women’s conceptions of the action of contraceptives on their bodies are pragmatic. Ethnogynecological perceptions of the importance of blood matching, combined with the importance of having small families for economic success, often encourage contraceptive use and mitigate the action of side effects rather than prompt nonuse or discontinuation.

Prudence is 33 years old with four children. Today she looks extremely tired and stressed, her head hanging and posture stooped as she sits in the yard of her compound. As the conversation turns to her children, she confides that she does not want to give birth any more. When I ask why, she explains that her husband has stopped providing her with things that she needs. He has left for a neighbouring community to

farm with his second wife, leaving Prudence in a state of constant stress and despair. She tells me that, given her current economic and marital situation, she will go to the family planning clinic soon to avoid giving birth again. A few months later, I saw Prudence walk into the clinic. She greeted me quickly, shyly and uncomfortably and then stood by the nurses and whispered: "I have just taken the injection, that was eleven days ago when I was bleeding. Now I am still bleeding. I am worried that I have not experienced this before". The nurses took Prudence into another room to ensure the bleeding was not too heavy.

Prudence's case demonstrates that fears about side effects of contraceptives in northern Ghana are very real, and that family planning is perceived to pose great risks to women's health and fertility. Drawing on ethnographic field research carried out in northern Ghana, this paper examines women's concerns about side effects and the impact of these concerns on family planning practice. I show that despite anxiety about side effects, and their real physical, social and economic consequences, women's conceptions of the action of contraceptives on their bodies are pragmatic and promote contraceptive switching rather than discontinuation.

Family Planning in Ghana

I conducted ethnographic research in Ghana in 2013 and 2014. Knowledge of contraceptive use in Ghana is almost universal, with 99% of women having heard of at least one family planning method (GHS and GSS 2015). Twenty seven percent of married women use contraceptives. However, national-level statistics for Ghana mask large local and regional differences in rates of contraceptive use. One third (32%) of women in the Greater Accra Region (South) use contraceptives, compared to only 11% in the Northern Region and 24% in the Upper East region (North) (GSS 2015).

Researchers and family planning program administrators consider these results to be discouraging signs of resistance to contraceptive use or the failure of family planning programs. This resistance has been attributed to women's fear of side effects (GHS and GSS 2015), especially to concerns about infertility, which is the most common reason reported in national demographic surveys for nonuse of contraceptives. In one of the few qualitative studies examining community perspectives on contraceptive use in Ghana, Adongo and colleagues (2014) argue that popular misconceptions about contraceptive side effects are impediments to contraceptive use, and call for improved access to qualified counseling. Drawing on ethnographic data, which allow for an in-depth understanding of gender, I examine contraceptive use in the Upper East region of

northern Ghana, a region with one of the lowest rates of contraceptive use in the country.

Family planning in sub-Saharan Africa

Contraception and family planning are important components of reproductive health services and have demonstrated positive effects on maternal and newborn health, including preventing unintended pregnancies and lowering rates of death associated with complications of pregnancy, childbirth and illegal abortions. Yet in 2014 an estimated 225 million women worldwide who wanted to avoid a pregnancy were not using a contraceptive method (UNFPA 2014).

Rates of contraceptive use vary considerably: in sub-Saharan Africa rates are lower than levels reported in Latin America and Asia (UNFPA 2016). Although much of the family planning literature assumes that the main barrier to family planning in sub-Saharan Africa is access to contraceptives, surveys suggest that fear of side effects may influence family planning decision-making even more than supply issues (Campbell, Sahin-Hodoglugil and Potts 2006). Concern about side effects is one of the most commonly cited reasons for women's non-use of contraceptives in sub-Saharan Africa, and the most common reason why women discontinue family planning, aside from contraceptive failure (USAID 2009; GHS and GSS 2015).

While studies find that some of these women's worries about contraceptives are based on uncomfortable or distressing side effects, such as menstrual disruption, nausea, weight gain and delays in fertility, researchers frequently focus on misinformation spread by rumour and hearsay (Campbell et al., 2006; Hindin, McGough and Adanu 2014; GHS and GSS 2015; Chipeta, Chimwaza and Kalilani-Phiri 2010) rather than on side effects themselves. Authors argue that health programs on the African continent should target eliminating misinformation and strengthening factual information about family planning by directing more resources toward providing high quality counseling and education (Chipeta, Chimwaza and Kalilani-Phiri 2010; Adongo et al, 2014; Castle 2003)

Studies of perceptions of family planning often narrowly focus on identifying 'incorrect knowledge' women hold about their bodies and about contraceptives (Hindin, McGough and Adanu 2014; Chipeta, Chimwaza and Kalilani-Phiri 2010). While understanding women's negative perceptions about side effects of contraceptives is important, these studies decontextualize women's concerns from the larger gendered context of their lives. Such decontextualization draws attention away from the real physical, social and economic implications that side effects and worries about them have; less attention is paid to gender issues than to fertility itself. Thus, although researchers often collect women's perceptions of

side effects of contraceptives, a gendered approach requires paying attention to the gendered social and cultural context in which fertility occurs (Riley 1997). A gendered approach also takes into consideration power structures that surround contraception, such as biomedical hierarchies of hospitals and medical clinics, which tend to privilege professional and medical expertise “while occluding ethnomedical knowledge and women’s embodied knowledge” (Inhorn 1993, 323; Jordan 1997). Without this scaffolding, the impact of side effects of contraceptives on women’s bodies, lives and family planning practice is difficult to discern, and recommendations for family planning programming and policy may fall short.

Women’s responses to health programs have as much to do with social relations of healthcare provision as with culturally-influenced beliefs (cf. Nichter 2008). For example, in their qualitative investigation of “myths and rumours” about contraceptive side effects in Kenya, Rutenberg and Watkins (1997) show that the social distance between women and nurses, created by nurses’ high education levels and maintained by their curt interactions with clients, lead women to feel more comfortable discussing contraceptives with their friends, which facilitates rumours.

While some side effects discussed by women fall into the category of “myths and rumours”, women are equally concerned about the impacts of commonly experienced physical symptoms, such as nausea, irregular

bleeding, and weight fluctuations (Rutenberg and Watkins 1997).

Conversations with women reveal, however, that they are often more worried about the impact of side effects on their relationship with their husbands than about physical consequences (Castle 2003). For example, after using an injectable contraceptive, a woman's normal menstrual cycle may be delayed by several months and she may experience temporary difficulties conceiving. While biomedically speaking, temporary infertility is considered trivial, to many women in sub-Saharan Africa it is a major concern (Castle 2003; Feldman Savelsberg 1999). Women's daily lives are grounded in a cultural reality in which temporary and permanent infertility is socially abhorrent, and a woman's adult status and marital security is largely the product of her children. In addition, in much of West Africa, the practice of polygyny is commonplace. Owing to competition between co-wives, it is paramount that women remain fertile and sexually desirable to their husbands. Infertility or a husband's loss of affection can contribute to the impoverishment of a woman through loss of child labour and by undermining her position in her marriage relative to her co-wives (Foley 2007; Feldman Savelsberg 1999).

Just as temporary infertility can be socially and economically problematic for African women, so too are menstrual irregularities that can be caused by some hormonal contraceptives such as the pill and the injectable. Castle's (2003) ethnographic work with adolescents in Mali

demonstrates that prolonged bleeding that can result from using hormonal contraceptives affects women's sexual and marital relationships. An Islamic woman who is menstruating, for example, is considered to be unclean and cannot pray, cook or have sex with her husband. Excessive bleeding may jeopardize a woman's relationship with her husband, who may fear that he will become ill from having sex with his wife or assume that she is infertile. Such fears may, in turn, prompt him to divorce her or to favour another wife or mistress emotionally or economically (Castle 2003). In Mali and Kenya, prolonged bleeding may also reveal a woman's secret use of contraceptives to her husband or other prying family and community members (Castle, Konate, Ulin and Martin 1999; Rutenberg and Watkins 1997)

Research into women's beliefs about contraceptive side effects often concludes that women's culturally informed knowledge about their bodies may lead to nonuse or discontinuation of family planning since it is inconsistent with biomedical understandings of the body. However, the direct link between women's perceptions of their bodies and nonuse of family planning has been questioned. For example, Bledsoe's (2002) work in the Gambia shows that women's biosocial understandings of their bodies facilitate the use of contraceptives. Gambian women understand that their reproductive capacity is affected by reproductive mishaps such as miscarriages and negative social relationships, and these views prompt

them to use contraceptives for spacing pregnancies rather than for limiting the number of children they bear. These practices encourage women to bear as many children as possible in a social and economic climate in which large numbers of children are welcome and necessary (Bledsoe 2002). Ethnographic research with Kassena women also highlights the gendered consequences of contraceptive side effects, and the importance of women's ethnogynecological knowledge for contraceptive practice.

Kassena-Nankana West District

I conducted ethnographic research in two villages in the Kassena-Nankana West District of Ghana's Upper East region, the second smallest region in Ghana and the poorest in the country. Both rural communities involved in this study are Kassena. Families involved are predominantly small-scale peasant farmers, with farming complemented by retail and petty trading. Few adult women or men have high levels of education or regular sources of income through wage employment. Villages are arranged in extended family compounds of about seven regular residents, comprising one or more nuclear families with a common male head. Descent among the Kassena is patrilineal and patrilocal, with marriages arranged by couples rather than by their parents, and payment of bridewealth recognizes the future birth of children to the patrilineage. Polygynous relationships represent a minority of unions. The practice of

formal polygyny has declined considerably, although some men continue to have “outside wives”, owing to the popularity of Christianity and the cost of raising and educating a large family, which increase rivalry between wives (c.f. Wa Karanja 1987).

Family planning programs in northern Ghana are funded by the Ministry of Health, but contraceptives are provided by the United Nations Population Fund at affordable prices. In the public sector, contraceptives are readily available at numerous venues, including district and regional hospitals and health clinics. In rural areas, community health nurses provide family planning services through the Community-Based Health Planning and Services Initiative, which places nurses in rural clinics to provide basic curative and preventative primary health services. Clinics provide one-on-one counseling as well as home visits (c.f. Phillips et al. 2012). Family planning education is also provided by nurses and community-based volunteers during child welfare clinics and community outreach.

Infertility and fertility control

In rural northern Ghana, as in much of West Africa, fertility is understood as a bodily resource that is the basis of women’s economic and social power and security. Children provide a wide range of social and economic benefits, especially in rural areas. Children ensure perpetuity of

the lineage, serving as a memory of and perpetuating their parent's reputation in their absence or after death. Perhaps most importantly, children are vital for completing tasks in the home and on the farm, and for the overall development of the community. In a context where few individuals have formal, salaried jobs with pensions and benefits or social insurance, remittances children provide to families are significant and essential for survival, especially when children become well educated and are employed in government work.

While sterility is problematic for men, the social consequences of infertility for women continue to loom larger (Tabong and Adongo 2011). For women, who continue to be disproportionately blamed for infertility, even temporary infertility is problematic and can lead to marital discord, divorce, and consequently economic struggle. Barrenness is not only linked to poverty but has serious social consequences, evoking pity, gossip, and insults such as accusations of witchcraft. While local and national development discourses emphasize risks *from* motherhood, women in my study were equally concerned about risks *to* motherhood (cf. Allen 2002).

Although Kassena women and men are concerned about infertility, they are also worried about having too many children. Women's discussions about the ideal number of children frame family planning as a helpful strategy to care for children in light of changes in the rural

economy. In particular, a positive view of family planning exists among the Kassena because it is necessary to limit family size to afford education for every child. Over the past few decades, declining agricultural yields have diminished the usefulness of children's farm labour. In view of these economic insecurities, it is not surprising that 72% of married women of reproductive age who participated in my study reported that they were currently using some form of contraception other than natural methods such as abstinence, rhythm or withdrawal. This is considerably higher than the estimate of 24% for contraceptive use among married women in the Upper East Region generated by the most recent Demographic and Health Survey (GHS and GSS 2015).

The gendered nature and social costs of fertility control

The majority of couples I interviewed (separately) discussed the need to adopt family planning together. However, Prudence's case, and focus group exchanges between young women, demonstrate that most women feel it is appropriate for them to use contraceptives secretly when communication and economic transactions between spouses are precarious, such as when a husband fails to provide for a woman or her children, favours another wife, spends his money on alcohol or concubines (instead of his wife and children), or wants to have more children than he and his wife can care for.

Even in good marital relationships, women are usually responsible for practicing contraception. Although male condoms are available and inexpensive, few married couples use them because married men believe “*ko ba yoma*”: that they reduce the pleasure of sex. As one middle-aged man exclaimed, using a condom is like putting meat in a bag and then trying to eat and enjoy it. Dislike of male condoms, coupled with the abundance of methods for women, means that family planning falls within the domain of women, an assertion that nurses often encounter while educating couples on home visits. Various types of family planning, including injections, implants, birth control pills, female condoms, and emergency contraception are available to women. The most popular method is the injectable Depo-Provera. It is popular because it only requires visits to the clinic every three months, and because its use can be hidden more easily from community members, and husbands, where necessary: it requires no visible bandages or packages of pills. Adopting contraceptives and navigating physical and economic consequences of resulting side effects is thus another responsibility faced by rural Kassena women in addition to a long list of other chores and tasks that includes childcare, cooking, farming and often trading.

The perceived dangers of contraceptive use

Although program strategies have actively addressed concerns about side effects, women's worries about the impact of contraceptives on their fertility and sexual desirability continue. Today, Kassena women and men argue that family planning is beneficial, owing to the economic importance of small families, but still express concern that contraception can lead to infertility, a delay in return to fertility, or other side effects that could jeopardize women's health. About one third of patients at clinics in the region are not new or continuing clients but rather women reporting concerns about side effects from a new contraceptive method.

Among married interlocutors, young women express the most concern about side effects. One young mother in a focus group expressed the typical female view that while family planning is positive, contraceptives can also have negative effects:

To me family planning is very good because it has helped us to decide on the number of children that we want to have. Also it has bad effects. Why? Because it can cause a problem of destroying your womb or delaying your childbirth. At the time you want give birth you may not get pregnant.

The most popular form of family planning, the injectable contraceptive, Depo Provera, generates considerable unease among women because of side effects such as delays in fertility, nausea, pain, and amenhorrea or excess bleeding. Delayed menses is believed to cause health problems or infertility and is thus perceived as a risk to a woman's health. As

elsewhere in the developing world (c.f. Castle 2003; Nichter 2008), menstrual blood is thought of as a dirty waste product that must be removed every month, and menstruation is thus envisaged as a process through which the womb is cleansed of impurities. One phrase for menstruation, “*a wo achana zare ne*”, literally translates to “I’m doing my monthly washing”. Amenorrhea is considered to lead to an accumulation of dirty blood inside the womb that takes time to be discarded in order for the womb to be clean enough for conception. In contrast, having too little blood in the body is linked to infertility.

In a social climate in which suspicions of infertility can be grounds for divorce or taking another wife (polygyny), and where children ensure continued emotional and financial support from husbands, amenorrhea and delayed fertility are yet another stress rural women face in addition to their daily worries about money and food. These side effects may also cause anxiety for women who wish to hide their use of contraceptives from husbands or other community members, or who fear their difficulties may interrupt important activities such as trading, carrying firewood, fetching water and farming, which are important for the social and economic well-being of women and their families (c.f. Rutenberg and Watkins 1997).

Women also have particular concerns about the injectable contraceptive because of associated weight gain, as focus group discussions revealed.

Moderator: What do you think of family planning?

Unmarried young woman: The injection can make you gain excess fat and that is not good

Elder: ...You know some contraceptives they have side effects. For instance, you can grow fat. Some men they don't want fat women, so they leave the women and go in for another one.

Weight gain is a side effect that produces anxiety for both men and women because slimness is an important aspect of feminine beauty.

Women are concerned that, if they gain too much weight, they will no longer be attractive to their husbands. Women's discussions reflect sexual and marital double standards, in which a wife should satisfy her husband sexually and remain desirable to him, otherwise she might cause his extramarital relationships. Women's ongoing concerns about infertility and the stability of their marriages reveal that while health programming has increased communities' acceptance of contraceptives, gender inequality and poverty persist.

Nurses are well aware of women's fears about side effects, and do their best to reassure their clients that they are not permanent or serious. Women's conversations and observations of nurse-client interactions suggest that nurses usually take the necessary time to counsel patients and to create a comfortable and flexible environment in which women are encouraged to present troubling side effects early and to switch to a method with minimal side effects or those that are acceptable. Although

investigation of reported side effects is thorough, women can end up paying as much as an additional fifteen cedis (four USD) for treatment of side amenorrhea or breakthrough bleeding, and these costs are not covered by health insurance. Clients with amenorrhea are first tested for pregnancy at the cost of four cedis. To correct irregular bleeding, women may receive one cycle of birth control pills at the cost of one cedi, or may be sent for an ultrasound scan to check for ovarian cysts or fibroids at the cost of ten cedis. These costs are significant for women, considering the daily average expenditure per person on food in northern Ghana is less than 0.5 cedis per day (see GSS, 2008); unexpected healthcare fees may lead women to make tradeoffs, which can lead to neglect of other needs essential for daily survival, such as food (cf. Nanda 2002).

“It doesn’t match my blood”

Married Kassena women understand that side effects of drugs, such as hormonal contraceptives, result from incompatibility between medication and their individual body or blood. In fact, when women not using contraception are asked which method they would like to use in the future, they often reply “*kulo na wo ma de amo jana to*”, the one that matches my blood or the one that matches my system. Fit between contraceptives and the unique bodily constitution of an individual woman is used to explain why a family planning method is effective for her, but not

for another person. Side effects are often interpreted by women as a sign of drug incompatibility (c.f. Nichter 2008). Christie, a forty year old woman with four children, commented on the importance of a family planning drug matching with a woman's system: "it is based on the way it will be within your system. For instance with this one I bleed normally, I don't feel any pain and I do my normal activities well. So it has really matched with my system". In other words, although several options are available, there is often one contraceptive that matches best with each woman's body. While family planning methods are considered to be risky, side effects are understood as a risk that can easily be mitigated.

Women believe that blood tests may help determine whether a particular method will match their bodies. Elaborating on the concept of blood compatibility, a young woman in a focus group discussion of benefits and consequences of family planning said: "to me they [the nurses] ask us to go for a blood test to determine the one [contraceptive] that is suitable for our systems and if care is not taken, it harms the individual". Women's descriptions of the importance of blood tests may reflect nurses' practice of measuring new clients' blood pressure prior to administering hormonal methods such as injections and birth control pills; women with high blood pressure who use hormonal methods may have an increased risk of cardiovascular events. The practice of testing blood

pressure may reinforce women's ideas about the link between blood and finding the right method of contraception.

Worries about side effects can prompt some women to delay returning for their next family planning appointment, which can result in a lack of protection, unintended pregnancy or even abortion. Fortunately, like Prudence, the majority of women interviewed in this study who experienced side effects returned to the clinic soon after experiencing them to discuss their concerns and to have them treated or switch to a method more compatible with their body. Kassena women's concepts of the body serve their interests by providing the opportunity to avoid unpleasant physical, economic and emotional experiences associated with side effects from contraception, while at the same time achieving a small family size necessary for economic success in a changing political economic climate. Women's ethnogynecological perceptions of "blood matching" can actually facilitate rather than block contraceptive use, by encouraging them to practice contraceptive switching rather than compelling them to stop altogether.

Conclusion

Attention to the gendered context in northern Ghana highlights real physical and economic costs of family planning. Rather than being simply a benign or primarily agency-promoting activity, contraceptive use has

tangible, often hidden, negative effects on Kassena women's emotional, physical, social and economic security. Despite observable and hidden costs of contraceptive side effects, and worries about their physical impact, Kassena women continue to choose to adopt contraceptives. Local gynecological perceptions of the importance of blood matching, combined with the importance of having small families for economic success, often encourage contraceptive use and mitigate the action of side effects rather than prompt nonuse or discontinuation.

A gendered approach reveals ways in which women's culturally-informed knowledge about their bodies can be mobilized. Family planning programs in northern Ghana should recognize and address women's concerns that contraceptive methods match with their individual bodies. Programmers could incorporate into their counseling and education activities contraceptive users from local communities who have successfully "matched" their family planning method.

Yet, perhaps most importantly, a gendered approach reveals that worries about side effects reflect much deeper social and economic concerns that cannot be addressed by family planning education or counseling. The typical technical approach, which emphasizes increasing contraceptive prevalence by improving nurse-client interactions, sidelines the real crux of the problem: socioeconomic and political dimensions of existing gender hierarchies and marriage arrangements. Ultimately, these

concerns underlie women's worries about side effects from contraceptives and point to the need for a strategic agenda aimed at reducing gender inequality.

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Chapter 6: Discussion and Conclusions

You cannot kill an elephant with one arrow. *Ba ba goe tuu de chene dedoa*
--Kassena proverb

While he was explaining to me why family size is declining, Isaac, a 77-year-old father of five living children used the proverb, “you cannot kill an elephant with one arrow”. Isaac contended that just as it takes many men with many arrows to kill an elephant, a multiplicity of processes have contributed to shifting family formation among the Kassena. Unity and plurality are of central importance in Kassena family life (c.f. Cassiman, 2006). Just as the Kassena house exists in the middle of the crossroads between multiple paths, Kassena women’s lives unify multiple houses of belonging, since once women are married, they continue to foster strong ties with their natal house, while also becoming deeply embedded in their husbands’ houses. Similarly, a child is created in the womb and brings together multiple qualities and spaces – this world and the otherworld. An ethnographic analysis, which aims to investigate the world from the perspective of communities, and occurs at the intersection of multiple methods, is particularly well-situated to delve into the complexities of the processes behind shifts in family size and contraceptive use in K-N West.

My fieldwork was conducted among the Kassena in northern Ghana in 2013 and 2014 under the umbrella of the Navrongo Health Research Centre. A central feature of my ethnographic project has been to “situate

fertility” (Greenhalgh, 1995) at the intersection of myriad social and economic processes, to contextualize Kassena men’s and women’s reproductive behavior in complex and nuanced ways that move beyond the conventions of demographic theory and research. My analysis of family formation and contraceptive use thus occurs at the crossroads of anthropology and demography.

I explored the following questions:

1. How has the desire for smaller families emerged in K-N West and to what is this transformation linked?
2. What role have family planning programs played in the reduction in family size in K-N West? Have they been the most important driver of the transition?
3. What are the current ideas about family planning and contraceptives in K-N West? Are they gendered? How have they changed over time?
4. Are the views about family planning and contraceptives in keeping with those of public health practitioners?

The answers to these questions draw attention to gaps between the narratives of communities about changes in family size and contraceptive use and ideas put forward in the public health literature and by health professionals. Together, the three papers that make up the heart of this thesis work to problematize the larger assumptions that frame family planning research and policy. I describe the ways in which my research raises questions about the importance placed on externally-developed indicators of success in family planning programs and research. I

challenge typical understandings of culture in global health research by examining the impact of culture on shifts in family size and contraceptive use in Kassena-Nankana West. Finally, my results highlight important aspects of the human experience that are neglected by classic public health approaches to reducing family size and increasing rates of contraceptive use. I argue that survey methods offer limited perspectives on the social circumstances that modulate family planning practice compared to ethnographic approaches.

1. How has the desire for smaller families emerged in K-N West and to what is this transformation linked?

Men's and women's discussions reveal that in Kassena-Nankana West, social and economic processes, such as the increasing importance of child education, declining agricultural yields and levels of child mortality, as well as changing marital practices, shape desires for smaller family sizes. The increasing value placed on gender equity in child education is one of the most important processes leading to smaller family sizes. Better work opportunities in the formal sector are available to educated children and generate higher family incomes and more substantial remittances for parents than farm work.

In the demographic literature, education is often assumed to be linked to lower fertility by empowering individuals, particularly women,

through a variety of pathways, for example, through improved economic opportunities and knowledge about family planning, which leads to contraceptive use and declines in fertility (Handwerker, 1989; Bradley, 1995; Bledsoe, Casterline, Johnson-Kuhn & Haaga, 1999). However, the Kassena-Nankana West results show how these explanations neglect the broader impact of schooling at the community level, as well as the importance of forces operating across generations. Education may affect ideals of family size, but not necessarily by imbuing women with knowledge and opportunities. Parents make choices about schooling girls in terms of the anticipated costs of educating future children, coupled with the opportunities educated girls are expected to receive. This acts to discourage large family size. The impact of education on fertility is linked to economic pressures on the preceding generation (c.f. Bledsoe, Casterline, Johnson-Kuhn & Haaga, 1999).

Kassena narratives of fertility decline also disrupt typical demographic understandings of the relationship between economic development, modernization, and fertility decline. Theories of fertility change retain a Eurocentric idealization of the history of Western society, in which “traditional” societies develop from a state of high fertility to a modern, economically progressive state of lower fertility. A modernization perspective assumes that “traditional” culture and family-making practices

are barriers to modern development, and that lower fertility improves life for everyone (c.f. Greenhalgh, 1995).

The Kassena study findings are in line with those of other anthropologists who show how existing family making practices reflect social and economic circumstances and suggest that economic development is intertwined with fertility decline, rather than the result of it. For example, Schneider and Schneider (1995) show how the reproductive behavior of landless labourers in nineteenth century Italy made sense given the context of constrained opportunities in which they lived. Similarly, the Kassena's family-making practices prior to fertility decline should not be seen as pragmatic and discrete individual choices, nor as a "traditional" family-making strategy. Instead, large families reflect upward wealth flows conditioned by the local agricultural economy, gendered inequalities and lack of access to education, family-planning commodities, and child immunizations – a context created by and embedded in a history of underdevelopment.

The Kassena narratives of fertility decline demonstrate that demographic assumptions about rationality, progressiveness, "tradition" and modern society should be regarded as ethnocentric and suspect. In K-N West, small family size and the adoption of family planning is regarded as a modern achievement; however, modernity is a double-edged sword where economic effects are dependent on social location. The intertwined

nature of narratives of poverty and fertility decline upsets the demographic assumption that smaller family sizes automatically free up more resources and improve well-being. Kassena parents' rationales for smaller family size, for instance, draw on worries about social problems, such as alcoholism, a relatively new phenomenon linked to poverty.

Although fathers such as Kojo picture small families as modern and dream of living in big houses with fences, gates and security guards, their position at the bottom of a capitalist system means they are unlikely to reach such lofty goals. Stories of migration, which accompany descriptions of changes in family formation, exemplify the historically-embedded development of Ghana's south at the expense of the north. These ethnographic examples reveal that the link between fertility and development is not a question of resource carrying capacity, but one of equity and power (c.f. Hartmann, 1999).

In Kassena-Nankana West, the impact of the increasing costs of raising children is also buttressed by a new economic rationality in which smaller families support modern lifestyles and desires. Young people's desires for a small number of well-fed and educated children raised in nuclear family settings are linked to their aspirations to be good citizens and gain status and prestige, and to their hope for a more successful life than that of their parents. Clearly, biopolitical intergenerational rationalities shape family size and contraceptive practice in K-N West.

The concept of biocitizenship has been used in different ways in the medical anthropological literature under a variety of terms, including “biological citizenship”, and ‘therapeutic citizenship’ (Petryna, 2002; Nguyen, 2008; Rose & Novas, 2008; Greenhalgh & Carney, 2014; Benton, 2015). Existing considerations of biocitizenship have already linked biosociality with global and national governance structures and gendered relationships (Petryna, 2002; Ngyuen, 2005; Greenhalgh & Carney, 2014; Benton, 2015). For example, Petryna (2002) uses biological citizenship to describe the claims made on the post-Chernobyl state by people with illnesses caused by radiation, and the political exploitation of these injuries. Similarly, in his work on HIV in West Africa, Nguyen uses “therapeutic citizenship” to describe “a form of stateless citizenship” in which multilateral institutions like the Global Fund take responsibility for public health services that the state has failed to provide. Following Rose and Novas (2008), I use the term biocitizenship to refer to “citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings as individuals, as families, and lineages, as communities, as population and races, and as a species” (Rose & Novas, 2008, p. 440).

In common with Rose, Novas (2008), and Petryna (2002), understandings of and actions surrounding family planning in K-N West are linked to individual and collective identities. While discussions of

biocitizenship have linked biosociality with gendered relationships (Greenhalgh & Carney, 2014; Benton, 2015), the narratives from K-N West illuminate the way biocitizenship can have a greater impact on citizens of a certain age. Among the Kassena, being a good citizen is linked to small family size through the act of providing children with the appropriate materials and social investments, such as clothing, schooling, and food. When young people adopt family planning, they not only consider the well-being of their own children and the larger community, but make the decision in the context of “political economies of hope” (Rose & Novas, 2005, p. 452) which tie together familial relationships and experiences throughout their life course and their hopes and aspirations for the future. These “political economies of hope” shape their visions of the ideal family. I argue that the younger generation acts as “ethical pioneers”; because of their attention to their children’s education; the current generation of young parents is demarcated as better biocitizens than the generations of their parents or grandparents. Elderly men and women, however, are not relegated to the bottom rung of biocitizenship, even though by today’s standards their approaches to childbearing are not considered pragmatic. Young people understand that at the time that elderly men and women had children, their strategies for family-making made sense, given the existing gendered and economic context of higher

child mortality rates, lower overall rates of education, and better agricultural conditions.

2. What role have family planning programs played in the reduction in family size? Have they been the most important driver of the transition?

In K-N West, changing perceptions of family size and family planning have been influenced by increased accessibility of contraceptives and knowledge due to the introduction and scale up of the Community Health and Family Planning Project (Dalaba et al., 2016). Aside from increasing the availability of contraceptives, the highly successful childhood immunization initiative, introduced as part of the comprehensive primary healthcare program, has reduced childhood mortality rates, making large families unnecessary in order to ensure that children would survive to support parents in their old age. In addition, larger national-level family planning campaigns, such as 'Life Choices', have assisted in the construction of biocitizenship discourses that encourage small family sizes. Similar to national rhetoric, the Kassena understandings of the benefits of family planning link fewer children to their aspirations for a better future and poverty reduction.

I argue that although family planning programs have influenced fertility decline and family making, larger socioeconomic processes have been the most important drivers of the transition. For instance, parents'

recognition of the importance of educating children to survive economically has contributed to their positive opinions about family planning. The costs of educating children, along with rising levels of Christianity, has decreased polygamy and supported more spousal communication about family planning. Nurses and clients alike distinguish between irresponsible men, who are 'ignorant' about family planning and their wives' and children's needs, and responsible women, who bear both childrearing and family planning. These discussions suggest that conceptions of responsible manhood are shifting, and are now linked with men's conjoined consideration of family planning with their partners.

There is a tendency in the demographic and public health literature to subscribe to diffusionist explanations for fertility decline (Greenhalgh, 1995; Casterline, 2001). Diffusionist explanations describe fertility decline as a process initiated by family planning programs that occurs by replacing traditional pronatalist family culture with modern perspectives. For example, in Kassena-Nankana West, Dalaba and colleagues (2016) attribute men's improved acceptance of family planning to the Community Health and Family Planning program without discussing larger social changes, such as the emergence of "companionate marriage" (c.f. Smith, 2007) that have shifted the culture of family formation and paved the way for men's changing attitudes. While much demographic research exists on spouses' changing knowledge, attitudes and communication practices

related to contraceptive use, (for example see Piotrow et al., 1992; Bawah, 2002; Shattuck et al., 2011) fundamental changes in the institution of marriages are often overlooked. Scholars suggest that spousal communication predicts contraceptive use, and that this communication is prompted by family planning programs (Piotrow et al., 1992; Shattuck et al., 2011; Bawah, 2002). However, I argue that among the Kassena, “companionate marriage”, coupled with conceptions of ideal manhood, have laid the foundation for increasing spousal communication about contraceptives.

Today, spouses in good relationships are expected to engage in discussions and mutual planning about family size and family planning. Ideals of marriage stress the importance of communication between spouses about topics like family planning and the quality of this communication is understood to be an expression of marital love and trust. Changes in Kassena ideals of marriage are in line with anthropologist Smith’s (2007) discussion of the companionate marriage in Southeastern Nigeria. He argues that the differences between modern Igbo marriages and the past are “most pronounced in narratives about courtship, in the way husbands and wives describe how they resolve marital quarrels and in the way they make decisions about and contribute to their children’s education” (Smith 2007, p. 999). Shifting ideals about spousal communication also have emerged as the practice of formal polygyny has

declined, owing to the popularity of Christianity, the cost of raising and educating a large family, increased economic hardship, and rivalry between wives. Polygyny has long been considered to have a negative impact on spousal trust and communication about reproductive decisions in sub-Saharan Africa through social practices such as separating mother-offspring units into their own economic and residential arrangements (Caldwell et al., 1987; Adongo et al., 1997).

3. What are the current ideas about family planning and contraceptives in K-N? Are they gendered? How have they changed over time?

Owing to larger political-economic shifts, contraceptives have become more widely acceptable in K-N West, especially by men, since baselines studies in the 1990s (Adongo et al., 1997; Bawah et al., 1999). As described above, men are more willing to discuss and support their wives' adoption of contraceptives than in the past. While some men suggested that it was wrong for a woman to adopt contraception secretly, none said that women who did so should be threatened or beaten. However, men's acceptance of contraceptive use is conditional; their degree of acceptance depends on the context in which family planning takes place and reflects gendered sexual scripts. For instance, men's dislike of condoms, coupled with the abundance of methods for women,

means that family planning remains the responsibility of women; additionally, unmarried women's use of contraceptives is still stigmatized and linked with ideas about uncontrolled sexuality.

While the idea that men need to be able to control female sexuality persists, it does not appear to be the barrier to contraceptive use that it once was since most men encourage their wives to adopt contraceptives. Despite improvements in men's acceptance of family planning, discourses of biocitizenship exaggerate the irresponsibility of men by portraying them as a significant barrier to contraceptive use. Distinctions between irresponsible men, who are ignorant about family planning and their wives' and children's needs, and responsible women, who bear both childrearing and family planning, are often made by both nurses and their clients. Similarly to other anthropological accounts, the current study demonstrates how the negotiation of reproductive decisions has become "a central arena of struggle, not only over women's bodies and lives but also over significant social concepts such as "the feminine" [and], "the masculine" (Kanaaneh, 2000, p. 162). While biocitizenship can reflect gendered realities, the current study suggests that they may also exaggerate them (c.f. Greenhalgh and Carney, 2014; Benton, 2015).

Today, Kassena women and men think family planning is beneficial, but still express concerns that contraceptive use can lead to infertility, a delay in the return to fertility, or other side effects such as amenorrhea,

menorrhagia or weight gain for women that could jeopardize their health or relationships. For women, the side effects of contraceptive use, especially irregular menses, create anxiety in a social climate in which children are necessary for survival and social status, and menstruation is understood to clean the womb. However, while the use of contraceptives is considered to be risky, ideas about “blood matching” mean that side effects are understood to be mitigated easily.

Kassena women’s concerns about the impacts of family planning on their health and fertility are based on culturally-informed understandings of the body that have been explored deeply by medical anthropologists. Much has already been written about local perceptions of menstruation and women’s bodily processes and the ways these ethnogynecological conceptions influence ideas about the links between fertility, health and family planning (Sobo, 1993a, 1993b; Buckley & Gottlieb, 1988; Foley, 2007; Rashid, 2007; Nichter, 2008). In common with the Kassena context, many medical anthropological studies have documented cultural understandings of menstruation as necessary for bodily purification and in which delayed menses is believed to cause health problems or infertility (Sobo, 1993a, 1993b; Buckley & Gottlieb, 1988; Castle, 2003; Foley, 2007; Rashid, 2007). Several of these studies document how perceptions of ethnogynecology influence the use of family planning methods (Castle, 2003; Rashid, 2007; Foley, 2007). While other

anthropological accounts of the impact of ethnogynecological perceptions draw attention to the ways that the discontinuation and nonuse of contraceptives is pragmatic, the Kassena narratives underline the way “local practical knowledge” (Nichter, 2008) about “blood matching” can also mitigate the action of side effects, promoting switching rather than abandoning the use of contraceptives.

The social consequences of the side effects of contraceptive use for women’s marital relationships, reflecting gendered realities and inequalities, loom large in the minds of Kassena women. Similarly, other ethnographic research illustrates that women’s views about reproduction and contraceptive use are rooted in complex, gendered social issues rather than merely in individual medical choices (Bledsoe, 2002; Castle, 2003). In Kassena-Nankana West, women’s anxieties about contraceptives are influenced by the biopolitics of marriage and reproduction; their discussions of contraceptive side effects reflect a sexual and marital double standard in which a wife is expected to provide her husband with children and satisfy him sexually and remain desirable, otherwise she might cause him to seek extramarital relationships.

4. Are views about contraceptives in K-N West in keeping with those of public health practitioners?

In the demographic and public health literatures, in Ghana and elsewhere, concerns about side effects are one of the most commonly cited reasons for women's non-use of contraceptives and the most common reason why women discontinue family planning, aside from contraceptive failure (GHS & GSS, 2015; USAID, 2009). Research on family planning often places emphasis on finding out what a population does not know about contraceptives. While some of the worries about contraceptives among K-N women stem from distressing side effects, such as menstrual disruption, nausea, weight gain and delays in fertility, researchers instead frequently focus on misinformation spread by rumour (Campbell, Sahin-Hodoglugil, 2006; Chipeta, Chimwaza & Kalilani-Phiri, 2010; Hindin, McGough & Adanu, 2014; GHS & GSS, 2015). The idea that cultural practices are only relevant when they obstruct scientific understandings of the body is problematic. Doing so leads to a skewed understanding of local words and deflects attention away from what people know and how this knowledge might assist in health promotion (c.f. Nichter, 2008).

The K-N results add to the scholarly critique of the idea that there is only one correct understanding of the body (c.f. Schepher-Hughes & Lock, 1987; Lock & Kaufert, 2001; Nichter, 2008) and show how this view can

obstruct a comprehensive understanding of the social and cultural issues that influence the adoption of contraceptives (c.f. Castle, 2003). The culturally-informed perceptions of blood matching expressed by Kassena women demonstrate that their beliefs are not necessarily a barrier to contraceptive use. Using family planning commodities is considered to be risky for women; however, ideas about “blood matching” mean that side effects are understood to be mitigated easily.

Women continue to worry about infertility, underscoring the divergence between the policies of population control that focus on the risks of *fertility* and local discourses in which *infertility* is feared (c.f. Allen, 2002). Although family planning programs are framed under the larger umbrella of reproductive health and rights – which supports women’s and men’s decisions to have the number of children they desire – they do not consider the importance of access to treatment for infertility. The absence of national services to address infertility has implications for the perception and use of contraceptives. The lack of treatment for infertility can serve to amplify worries about the link between contraceptive side effects and permanent infertility.

Population programs are often advertised as ensuring the well-being of women and supporting the health and development of communities; however, they also have hidden effects. Women in Ghana may have to pay as much as an additional fifteen cedis (four USD) for

treatment of side effects of contraception such as amenorrhea or breakthrough bleeding, and these costs are not covered by health insurance. It is common practice for public health professionals to advocate reducing the hidden costs of maternal healthcare in sub-Saharan Africa; nevertheless, the policy implications of hidden fees associated with other important reproductive health services, such as family planning, have received limited discussion. Ghana, for example, has been recognized for its free Maternal Health scheme and National Health Insurance Scheme (see Whitter, Adjei, Armar-Klemesu & Graham, 2009); however, neither of these policies exempts women from paying out of pocket for essential services like family planning.

It is important to take into account the ways in which hidden fees associated with contraceptive use may exacerbate women's economic vulnerability. Nanda notes that poor women who must pay unexpected healthcare fees often have to make tradeoffs, which can lead to debt, or neglect of other amenities such as food, which are essential for daily survival (Nanda, 2002). While I did not discuss such tradeoffs with women in the family planning clinic, it was evident that many women had difficulty affording hidden fees. To enhance the affordability of contraceptives for the general population, the government of Ghana recently passed a law to allow the cost of contraceptive commodities to be covered by the National Health Insurance Scheme (GHS & GSS, 2015). Unfortunately, the law is

not yet in effect, nor will it consider the hidden costs of contraceptive side effects once it is implemented.

Conclusions and Recommendations

Drawing on ethnographic data from a variety of sources at different levels of observation, I have examined Kassena men's and women's perspectives on changing family size and family planning practices in northern Ghana. Kassena men's and women's discussions reveal the importance of broader social and economic events for changing norms surrounding family size and contraceptive use. Prior to the fertility decline from 6.6 to 4.1 that occurred from the late 1980s to 2008, family-making practices reflected upward wealth flows conditioned by the local agricultural economy, gendered inequalities and lack of access to education, family-planning commodities, and child immunizations – a context created by and embedded in a history of underdevelopment.

The processes that led to fertility decline among the Kassena include declining agricultural yields and levels of child mortality, as well as an increased focus on child education, husband wife communication, and conversion to Christianity. The shift to smaller families has been accompanied by a process in which new idealized bodies, forms of parenthood and families are created and linked to good citizenship. Parents who “take care” of children are deemed good citizens. Young

people's discourses of biocitizenship link well-cared for families to new modern lifestyles and desires, including the hope that families will live in blockhouses built with children's remittances. These emerging ideas of ideal-family-making are negotiated and formed within the context of intergenerational relationships, in which young people's desires for fewer children are linked to new "political economies of hope" (Rose & Novas, 2008, p. 452).

The K-N West study findings are in line with those of other anthropologists, who disrupt cultural-barrier explanations to show how existing family making practices reflect social and economic circumstances (Scheider & Schneider, 1996; Jeffry & Jeffry, 2002; Krause, 2005; Maternowska, 2006). A major contribution of this thesis is its illustration that contrary to demographic findings, lower fertility is not a panacea that will generate "modernity". Although family size has declined, high levels of socioeconomic deprivation continue to push Kassena people to the margins. Ultimately, this thesis highlights gaps between local understandings of successful development and family formation, and externally-promoted measures of change and success such as lower fertility rates.

A second major contribution of this thesis is its call for greater exploration of the social context of both women's and men's lives in which contraceptive use takes place. Despite declining fertility in K-N, distress

about the potential impact of contraceptives on women's health and fertility remains. Women's and men's worries about contraceptive side effects, including the impact of irregular bleeding, weight gain and delays in fertility, underscore the social consequences of contraceptives. The responses of Kassena women indicate that their decision-making around choice of contraceptive, and whether or not to discontinue a contraceptive due to side effects, is influenced more by concerns about the social consequences of infertility than by other commonly used demographic indicators, such as current risk of pregnancy and the quality of services. The hidden costs of family planning carried by women include bearing the responsibility of using contraceptives and enduring their side effects, and incurring fees for side effects that must be investigated and treated.

Similarly, men's increasing acceptance of contraceptive use is supported by a larger social context which includes political economic shifts such as declining agricultural yields. In order for men to support contraceptive use, they must see the social and economic benefits of limiting family size such as its usefulness for ensuring children's higher education. Program messages focused on the economic benefits of limiting births are a useful entry point for engaging men in reproductive change because they are supported by contextual social and economic processes that are intergenerationally-patterned.

Most health research focuses on the importance of strengthening the counseling and education component of family planning programs (Castle, 2003; Chipeta, Chimwaza & Kalilani-Phiri, 2010; Hindin, McGough and Adanu 2014; Adongo et al., 2014). I recommend that programmers also pay more attention to the social context of family planning. This can be achieved by first, working to absorb the costs of hidden fees. Second, health professionals can mobilize women's culturally-informed knowledge about "blood matching" to incorporate the stories of contraceptive users who have successfully "matched" their family planning method. There is a tendency in global health worlds to dismiss local cultural understandings and specificities because they get in the way of notions of large-scale comparisons and scaling up implementation (c.f Adams, Burke & Whitmarsh, 2014). However, Lock and Nguyen's (2001) concept of "local biologies", which refers to local experiences of the self and the body, sheds light on "how different notions of biology are relevant to larger frame-works of intervention and to different conceptualizations of what an 'intervention' might mean" (Adams, Burke & Whitmarsh, 2014, p. 184). In Ghana, global and national mandates that treat locally-specific boldily knowledge as inferior impede local effectiveness; more attention to local specificities such as "blood matching" would improve existing family planning programs.

In addition, for the concept of reproductive health and rights to be meaningful, integrated approaches to programming that allow women and men opportunities to access both contraceptives and treatment for infertility should be explored (c.f. Tabong & Adongo, 2013). Although family planning programs are framed under the larger umbrella of reproductive health and rights, which supports women's and men's decisions to have the number of children they desire, programs do not consider the importance of access to treatment for infertility. Infertility remains a terrible fate linked to poverty and stigma that can result in divorce and insults. The absence of national services to address infertility concerns has implications for perceptions of contraceptives and their use. A lack of treatment for infertility can serve to amplify concerns about the link between contraceptive side effects and permanent infertility.

Another contribution of this thesis is its call for closer attention to the larger context of gendered inequality in which contraceptive use occurs. Men's and women's worries about family planning reflect much deeper social and economic concerns that cannot be addressed by family planning programs alone. In Kassena-Nankana West, concerns about contraceptives are influenced by the biopolitics of marriage and reproduction. For instance, women's discussions about contraceptive side effects reflect sexual and marital double standards, in which a wife is expected to bear children and satisfy her husband sexually. Similarly, the

concept of family planning is still linked with men's worries about not being able to control women's bodies. For example, although husbands worry less that married women who use contraceptives will become promiscuous, unmarried women's use of contraceptives is stigmatized and linked with ideas about uncontrolled sexuality

Women's ongoing concerns about infertility and the stability of their marriages and men's conditional acceptance of family planning reveal that while health programming has increased the acceptance of contraceptives, gender inequality persists. The grip these social and economic issues have on women's bodies cannot be countered solely by a technical approach focused on men's knowledge of contraceptives, or by improving nurse-client interactions (Dalaba et al., 2016, Adongo et al., 2014).

High quality, comprehensive counselling sessions and group education sessions with men of all ages are important, especially when delivered within the context of a community-based primary healthcare program. However, a strategic agenda aimed at the underlying determinants of health and reproductive autonomy, including gender inequality, is equally necessary. Such an approach requires revisiting the revolutionary principles raised by the 1978 Alma Ata declaration: equity, social justice, community participation and intersectoral action (Lawn et al., 2008). Although these approaches to healthcare delivery have been

discussed for decades, their prioritization has been weak, especially with regard to the integration of non-health interventions with reproductive health care and family planning policy.

Ultimately, this thesis underscores the importance of a nuanced, context-dependent approach to the study of fertility and family planning. While large-scale, often survey-based approaches are important for understanding broad trends, these analyses neglect to provide a more detailed account of the role of the plurality of social and cultural processes at play in determinations of family size and contraceptive use. Demographic approaches, which often focus on fertility rates as their object of analysis, are considerably different from an anthropological lens, which goes beyond the numbers to focus on how families are formed and explores the ideas that underpin that formation. An anthropological approach carries different fundamental assumptions about culture and family-making, including a holistic concern with “on the ground”, culturally-relevant categories and local knowledge – “the native’s point of view” (Geertz, 1973). Ethnographic studies bring to bear a broader and more variable range of data on the understanding of population processes, which, in combination with demographic data, promise to provide a nuanced depiction of human perceptions and activity. Such a lens aims to create “whole demographies” that centre on local histories and the relationships between culture and political economy, rather than

“reproduce[ing] the functionalist myth that culture can be taken out of social, economic and political organization” (Greenhalgh, 1995, p. 9). An anthropological approach, which relies heavily on participant observation, also requires what Nancy Scheper-Hughes terms “the practice of witnessing”, an engaged approach that moves beyond qualitative methods to focus on “looking, touching, seeing, feeling and reflecting with people on the key experiences and moral dilemmas of their lives...” (Scheper-Hughes, 1997, p. 218). For understandings of fertility change and contraceptive use to be improved, a collaborative approach that involves partnerships between anthropologists, demographers and health professionals needs to be forged at the outset of research project design.

Future Directions

If fertility rates are not appropriate indicators of local public health success, and a focus on family planning eschews myriad other social and health problems, then this begs the question, how are priorities for maternal and child health decided? Another question along the same line of inquiry is: Who is involved in these decisions, and what evidence informs decision-making? These larger questions that have emerged from this research project are timely, considering the recent release of the UN’s new Sustainable Development Goals (SDGs), which promotes a vision of inclusive, people-centered development. SDG goals seek to achieve a

process of development that emphasizes local priorities, a shift from a previous focus on prescriptive global targets, emphasized by the Millennium Development Goals, to broader initiatives that are nationally and locally adaptable, and recognize diverse social and economic circumstances (UN, 2012). While the SDGs' vision to promote people-centered and inclusive development is commendable, a turn to local and national ownership of development priorities will not likely be a simple task, especially when detailed, ethnographic studies are not written into the research design from the outset.

The lack of resources in low and middle-income countries such as Ghana has led to the involvement of international stakeholders, including multinational organizations such as the World Bank, whose agendas are often distinct from those of national governments. The involvement of these actors can distort national and local priorities. What's more, so-called participatory development processes have been reported to exclude certain actors such as local communities (Pfeiffer & Chapman, 2010). In addition, studies show that an over-reliance on metrics in global health can also lead to a type of violence, in which certain types of "good data" become political praxis, "a lingua franca by which people negotiate global citizenship, sometimes at the expense of national sovereignty" (Adams, 2016, p. 226), rendering some stories invisible.

Anthropologists working in global health have a duty not only to point out failures and the way they work against health but to explore and pursue new models that may be worthwhile (Adams, 2016). To investigate how decision-making about priorities in maternal and child health occurs, and to offer recommendations for improvement, ethnographic research, in combination with integrated knowledge translation should be conducted. This type of KTE could be line with what Adams and colleagues (2014) term “slow research”, which focuses on local research efforts that are pluralizing, rather than globalizing, and are tailored to specific sites.

Through partnerships with Ministries of Health and local communities, a series of stakeholder interviews could be carried out, in combination with traditional methods of ethnographic participant observation, which involve “sitting” as an imperative for critical reflection (Pigg, 2013) to examine the relationship between global, national and regional priority setting exercises for maternal health. Since there is limited knowledge of how much local actors are involved in these new priority setting processes, and what types of evidence inform decision-making, such a project would provide a unique opportunity to examine whether the global focus on inclusive development is resulting in improved health at the local level.

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Appendices

Appendix A: Genealogy

GENEAOLOGY **Interviewer** **Date**(dd/mm/yyyy)
Location of interview [] respondent's home [] other place:

RESPONDENT

Partnership: single [] married [] divorced [] widowed []

Respondent's study ID

Born Place
 Mar: Place
 Respondent's Father Respondent's Mother
 Respondent's other spouses:
 Occupation:

PARTNER

Born Place
 Died. Place (Place buried):
 Partner's Father Partner's Mother
 Partner's other spouses:

Notes:

GENEALOGY

Interviewer:

Date(dd/mm/yyyy):

RESPONDENT:

Sex	Bio Adopt Foster	Reside w/res Y/N	Children's Names	Current Residence	DOB	Birth Place	Other parent(s)	D.O. 1st marriage	D.O. death
								To whom	
1									
2									
3									
4									
5									
6									
7									
8									
9									

GENEAOLOGY Interviewer:

Date(dd/mm/yyyy):

RESPONDENT:

Sex	Bio Adopt Foster	Reside w/res? Y/N	Siblings	Current Residence	D.O.B	Birth Place	Other parent(s)	D.O. 1 st marriage	D.O. death
								To whom	
1									
2									
3									
4									
5									
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Notes:

Appendix B: Focus Group Guide for Youth

1. Would you like to have children in the future? Why or why not?
 - What are the main reasons for having children in this community?
 - Does having children impact a person or their compound positively or negatively?
 - How many children would you like to have?
 - Would you like your children to be a specific gender? Why or why not?
 - What roles would children, specifically, boys and girls play as they grow up?
 - What activities are girls expected to perform in the house? What activities are boys expected to perform in the house?
2. How does the community react to a woman or a man who does not have a child? Who does not have a son?
3. Do other members in a family compound care for children other than their own? [Please describe]
4. How many women can a man marry in this community? Why?
5. What are the main roles that men play in the household? In the community?
6. What are the main roles that women play in the household? In the community?
7. Can a woman sell her own produce or livestock?
8. Can a woman go out of the compound without informing her husband?
9. Can a wife refuse to have sex with her husband?
10. Can a woman go to a soothsayer?
11. Can a woman decide on her own to limit the number of children she will have?
12. What do you think about family planning?
13. How do you plan to space your children? Do you plan to use any methods? For what reason will you use this particular method?

Appendix C: Focus Group Guide for Married Adults

1. These days, what leads some people to have many children?
2. These days, what leads some people to have fewer children?
3. Does having children impact a person or their compound positively or negatively? [Please describe].
 - Under what circumstances would having a child have a positive impact?
 - Under what circumstances would having a child have a negative impact?
4. Do people want their children to be specifically male or female or both?
Why?
 - What benefits do boys or girls have for the household?
 - What activities are girls expected to perform for the family? What activities are boys expected to perform for the family?
5. Do other members in a family compound care for children other than their own? [Please describe]
6. These days, how does the community react to a woman or a man who does not have a child? Who does not have a son?
7. How many children do each of you have now? Do you want to have more children?
 - What has led you to come to this decision?
 - Do you want your next child to be a boy or a girl? Why or why not?
8. These days, can a woman sell her own produce or livestock?
 - Can a woman go out of the compound without informing her husband?
 - Can a wife refuse to have sex with her husband?
 - Can a woman go to a soothsayer?
9. Can a woman decide on her own to limit the number of children she will have? [Please describe]
10. What do you think about family planning?
 - What has led you to think this way about family planning?
 - If you are comfortable doing so, please describe your experiences with family planning or the experiences of people you know in general.

11. How have you spaced your children? What led you to space them this way?
 - Did you use any methods?
 - For what reason did you use this particular method?
 - How do you plan to space your children in the future?

12. Please describe your experiences with the Kalvio clinic.
 - Have you or anyone else you know ever faced challenges in obtaining
obtaining
 - health care? [Please describe]
 - Have you or anyone you know ever faced challenges in obtaining
family planning methods? Why or why not? [Please describe]

Appendix D: Focus Group Guide for Older Adults

1. Does having children impact a woman positively or negatively?
[Please describe].
 - Under what circumstances would having a child have a positive impact on a woman?
 - Under what circumstances would having a child have a negative impact on a woman?

2. Over time [since the time you were first married] has the number of children that women give birth to changed?
 - Has it increased, decreased or stayed the same?
 - [If you think women are having fewer children these days] what do you think is causing this?
 - [If you think the number of children has changed] What impact does this change have on the community?

3. These days, do people want their children to be specifically male or female or both? Why?
 - What impact do boys have for the household these days?
 - What impact do girls have for the household these days? Is this different than in the past?

4. Have ideas about marriage changed since the time you first married?
 - If yes, what do you think has led ideas about marriage to change?
 - These days, how many women do men marry in this community? Is this different than in the past?

5. These days, can a woman sell her own produce or livestock? Is this different than in the past?
 - Can a woman go out of the compound without informing her husband? Is this different than in the past?
 - Can a wife refuse to have sex with her husband? Is this different than in the past?
 - Can a woman go to a soothsayer? Is this different than in the past?
 - Can a woman decide on her own to limit the number of children she will have? Is this different than in the past?

6. These days, how does the community react to a woman or a man who does not have a child? Who does not have a son?

7. How did you space your children?
 - Did you use any methods?
 - For what reason did you use this particular method?
8. What do you think about family planning?
 - If you are comfortable doing so, please describe your experiences with family planning or the experiences of people you know in general.
9. Please describe your experiences with the Kalvio clinic. Have you or anyone else you know ever faced challenges in obtaining health care? [Please describe] Or family planning methods or information? Why or why not? [Please describe]

Appendix E: Focus Group Guide for Nurses

1. Do you think promoting family planning is beneficial? Why or why not?
2. In your opinion what are the most positive aspects of the way that family planning contraceptives and education are delivered?
3. What are the biggest challenges that you encounter in promoting the idea of family planning?

→to community members i.e. the social and cultural system

→because of the health system

→in your opinion, how can these issues be addressed?

→One thing that I have witnessed is that about half of the participants come in as continuing clients/new acceptors and then the other half are those women who are concerned about the side effects and some of these women discontinue the methods because of this. Why in your opinion do women have so much concern about the effects on bleeding in particular and what can be done to deal with this concern?

4. What is the policy on involving men in family planning? What are the difficulties in fulfilling this aspect of the program?

Appendix F: Interview Guide for Youth

1. Do you see yourself as different from your parents? From the previous generation?
2. How many children would you like to have in the future?
3. How many boys and how many girls?
4. Are girls as useful as boys?
5. How do you plan to space your children and why?
6. What do you think of family planning?
7. As you only want __ children, do you intend on using family planning? If so, which method and why?
8. [For men] Do you want more than one wife? Why or why not?
[For women] Do you want a co-wife? Why or why not?

Appendix G: Interview Guide for Married Men and Women

1. Why do you think people are having fewer children these days?
2. Do you want more children?
[if yes, should they a girls or boys? Why?]
3. What are the main benefits of having children in general? What are the main consequences?
4. What do you see as the purpose of marriage?
5. What do you see as the benefits and consequences of marriage?
6. Have you used any methods to limit the number of children you have?
Why or why not?
7. [If yes, discuss choice of specific method]
8. [For women] Did you discuss using family planning with your husband before you started? Why or why not?
9. [For men] Who suggested using family planning, you or your wife, or both? Why or why not?
10. Do you think family planning is good? Why or why not?
11. Do you think that the services at the clinic and family planning compound are good? Why or why not?



Appendix H: Life History Interview Guide

1. What do you think an ideal Kassena family is like?
(If participants are able, they are asked to draw an image of what they think an ideal family should look like and discuss it)
2. Do you think that you grew up in the ideal situation, the way you would have thought life should be?
→ Would you have wished your life as a child/your family to be different from how you have been brought up? Why or why not?
3. Now I would like you to describe the important events in your life in childhood to adulthood. Events that have affected your life today in a positive or a negative way.
→ [if applicable] When did you begin school? What was that like?
When did you stop schooling? Why?
→ Can you tell me about your first sexual experience? Was it with your husband/wife?
→ How did you meet your husband/wife?
→ Did your parents approve of the man/woman?
→ What were your expectations of your husband/wife when you first married? Were they met? Why or why not?
→ Has your relationship changed since you met him/her? What makes your relationship today good/bad?
4. Describe a time in your life that you were very happy, sad/depressed? Why?
5. [For women] Tell me about your first pregnancy and birth. How did you feel?
6. [If applicable] Referring to genealogy, discuss the reasons for certain spacing between children and why spaces were shorter/longer
7. What are your hopes and dreams for your future and your family's future?

Appendix I: Interview Guide for Policymakers

1. Please describe your role in [organization]. What has been your experience with family planning programs?
2. So what do you think are the major challenges in delivering family planning in terms of the health system?
3. What are the major challenges in delivering family planning culturally?
4. Overall do you think that family planning is such an essential component of primary health care in Ghana? Why or why not? If yes, what are the main benefits of family planning?

Appendix J: Approval Letter from McMaster University's Research Ethics Board

 <small>Inspiring Innovation and Discovery</small>	McMaster University Research Ethics Board (MREB) c/o Research Office for Administrative Development and Support, MREB Secretariat, GH-305, e-mail: ethicsoffice@mcmaster.ca CERTIFICATE OF ETHICS CLEARANCE TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH		
Application Status: New <input checked="" type="checkbox"/> Addendum <input type="checkbox"/> Project Number: 2013 081			
TITLE OF RESEARCH PROJECT: Perspectives on Family Size and Family Planning in Ghana			
Faculty Investigator (s)/ Supervisor(s)	Dept./Address	Phone	E-Mail
A. Herring	Anthropology	23915	herring@mcmaster.ca
Student Investigator(s)	Dept./Address	Phone	E-Mail
L. Wallace	Anthropology	289-925-9244	wallalj@mcmaster.ca
The application in support of the above research project has been reviewed by the MREB to ensure compliance with the Tri-Council Policy Statement and the McMaster University Policies and Guidelines for Research Involving Human Participants. The following ethics certification is provided by the MREB: <input type="checkbox"/> The application protocol is cleared as presented without questions or requests for modification. <input checked="" type="checkbox"/> The application protocol is cleared as revised without questions or requests for modification. <input type="checkbox"/> The application protocol is cleared subject to clarification and/or modification as appended or identified below:			
COMMENTS AND CONDITIONS: Ongoing clearance is contingent on completing the annual completed/status report. A "Change Request" or amendment must be made and cleared before any alterations are made to the research.			
Reporting Frequency:		Annual: May-08-2014	Other:
Date: May-08-2013		Chair, Dr. B. Detlor / Vice Chair, C. Anderson: 	

Appendix K: Approval Letter from the Navrongo Health Research Centre's Institutional Review Board

In case of reply the number and date of this letter should be quoted.

My Ref. App/Famplan/07/2013
Your Ref:



Navrongo Health Research Centre
Institutional Review Board
Ghana Health Service
P. O. Box 114
Navrongo, Ghana
Tel/Fax: +233-3821-22348
Email: irb@navrongo-hrc.org

11th July, 2013

Ms. Lauren Wallace
Department of Anthropology
McMaster University
Hamilton, Ontario, Canada

APPROVAL ID: NHRCIRB159

Dear Ms. Wallace,

Approval of protocol titled "Perspectives on Family Size and Family Planning in Ghana"

Following your satisfactory address of the concerns raised by the NHRCIRB during its review of the above-mentioned protocol, the Board is pleased to grant you approval. Below is a list of the documents that were reviewed and approved by the Board:

- Study protocol Dated 8th May, 2013
- Verbal Script for Recruitment of Community Members Version 2.0
- Verbal Script for Recruitment of Health Workers Version 2.0
- Oral Consent for Focus Groups with Community Members Version 2.0
- Letter of Information for Focus Groups with Community Members Version 2.0
- Written Consent/Letter of Information for Focus Groups with Health Workers Version 2.0
- Letter of Information for Genealogy and Social Network Analysis with Community Members Version 2.0
- Oral Consent for Genealogy and Social Network Analysis with Community Members Version 2.0
- Letter of Information for Interviews with Community Members Version 2.0
- Oral Consent for Interview with Community Members Version 2.0
- Written Consent/Letter of Information Interviews with Health Workers Version 2.0
- Curriculum Vitae of investigators.

Please note that any further amendment to these approved documents must receive prior NHRCIRB approval before implementation.

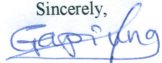
Data gathered for the study should be used for the approved purpose only.

The Board should be notified about the actual start date of the project and would expect a report on your study, annually or at the close of the project, whichever ever comes first. Should you require a renewal of your approval, the report should be submitted two (2) months before the expiration date.

You are also to note that this approval expires on 10th July, 2014.

The Board wishes you all the best in this study.

Sincerely,



Mrs. Gifty Aninanya
(Board Member, NHRCIRB)
For Board Chair, NHRCIRB
Cc: Director, NHRC



Mrs. Miriam Diana Abagale
(IRB Administrator, NHRCIRB)