


Spring 2012

'Boys Boys' Talk, 'Girls Girls' Talk: Gendered Approaches and Strategies towards Modern Contraceptive Use in Urban Kumasi

Yasmin Boakye
SIT Study Abroad

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School for International Training
Study Abroad Ghana: Social Transformation and Cultural Expression

Spring 2012

**‘Boys Boys’ Talk, ‘Girls Girls’ Talk:
Gendered Approaches and Strategies towards Modern
Contraceptive Use in Urban Kumasi**

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Data Collection: 3 APR 12 to 3 May 12

Abstract

1. Title: ‘Boys Boys’ Talk, ‘Girls Girls’ Talk:

Gendered Approaches and Strategies towards Modern Contraceptive Use in Urban Ghana

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3. Objective: The objectives of this project were three-fold:

1. How do men and women in the urban area of Kumasi come to understand the major forms of contraception available in Ghana?
2. Are there significant differences in the ways that men and women come to understand contraceptive methods, and are these differences influenced by region, religious affiliation, age, and socioeconomic level?
3. How are these understandings either reinforced, shifted, or broken down by the Ghanaian government’s reproductive health efforts, the work of NGO’s focused on family planning, religious beliefs, and social relationships?

4. Methodology: During the 30 day long research period I conducted fieldwork in various parts of Kumasi, including the KNUST campus and the neighboring areas Ayudase and Anwomaso, with the help of three research assistants who were peer educators at PPAG’s Young and Wise center on the KNUST campus. I interviewed 50 participants (25 men/25 women), and in selecting these individuals I specifically looked for individuals from a wide variety of age, religious, and educational backgrounds. Each participant agreed to answer a series of twenty questions about their understanding and feelings towards contraceptive use and family planning, as well as the influences of friends, media campaigns, and family upon these views.

5. Findings: My research indicated that a wide variety of factors plays a role in an individuals’ understanding of contraception, regardless of gender. With the exception of educational level (which tended to correspond with an increase individuals’ knowledge of contraceptive methods), very few of the factors associated with contraceptive understanding (religious affiliation, socioeconomic level, etc.) seemed to play a solitary role in determining one’s contraceptive views. In actuality, most views were shaped from a variety of life experiences that either reinforced or broke down the individuals’ initial approach towards contraceptives.

6. Conclusion: Though on a macroscopic level it was difficult to isolate specific gendered differences between the ways that men and women tend to understand contraception, individually, it became clear that the social milieu surrounding an individual plays a large role in his or her views on contraceptive use, and that often this social group is single-gendered. Men’s views tend to be reinforced by other men, and women’s views are reinforced by other women. Both men and women seemed to believe that their own gender was forced to bear the most responsibility in regards to contraception, though this view was much more prevalent in women than men. Finally, both men and women recognized that many of their views and those of the people they knew were based upon rumors and anecdotes, and many offered additional education both in and outside of the school as a means for improving overall understandings of contraceptives across genders.

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Introduction

While walking or driving down Osei Tutu II Blvd, the stretch of road in Kumasi that extends all the way from Accra into the heart of the city, it is difficult to miss billboards of any sort. Advertisements highlighting fertility enhancement medications, food products, energy beverages, skin lightening creams, and local hotels flank each side of the road, coercing readers to seek out their wares with catchy slogans and enticing models.

Naturally, after weeks of passing back and forth down the same portion of this road, I found many of these images emblazoned into the back of my mind's eye – the photograph of the family surrounding the can of Ideal Milk that comes right before reaching Amakom Junction, the red-and-orange bottle of Energizing Gluconade, the containers of Skin Light painted onto the wall opposite KNUST, and the flowing patterned dress sweeping the feet of the model advertising DaViva fabrics near the turn towards Adum's Central Market.

While I wasn't particularly surprised or perturbed by my inability to remove these images from my head, I did find myself intrigued by the way that public service advertisements regarding safer sex and family planning were also among the heavy number of billboards that line many of the streets in urban areas of Ghana. In the town of Krobo-Odumase in the Eastern region, I distinctly recall a massive billboard advertising the ABC method of avoiding sexually-transmitted diseases and infections – Abstain, Be Faithful, and Condomize – primarily because the billboard was much larger than any of the ones simply advertising products for sale. There were similar posters and billboards in every major town that I visited in my time travelling throughout Ghana – on the Legon campus of the University of Ghana near the African Studies building, and in many areas of Cape Coast and Tamale.



Figure 1.1 (courtesy Google Images)

In thinking about how difficult it was to stop thinking about such a wide variety of advertisements, slogans, and images, I found myself wondering how Ghanaians incorporated constant warnings against STDs and unplanned pregnancy into their understandings of contraception. Looking at the different ways that these billboards utilized slogans, mnemonic devices, and scare tactics and juxtaposing their blunt and basic text against the oft-repeated idea that Ghanaians tend to be very private in regards sexual attitudes piqued my interest in understanding the ways that people come to form their sexual belief systems and overall opinions on the variety of modern contraceptive methods that have come to be available to them in the urban areas of Ghana.

My project was also influenced by the stark contrast I noticed in access to information on contraceptives in rural Ghana; specifically the Mampong region of Ghana and the smaller communities of Nyiampong and Benim surrounding the region's capital. As one drives by taxi or walks down the curved road that connects Mampong, the district capital, to Nyiampong and Benim, just about twenty to thirty minutes away, there are fewer and fewer billboards, until there

are none at all. In the town of Nyiampong, where approximately 500 men, women, and children resided, there was only a single convenience store that did not stock condoms, and no chemist at all, with the exception of a single gentleman who rode a bike with a basket of common medications for sale through the town from time to time.

In Nyiampong's JHS, a meeting with the teaching staff revealed that there are a number of additional problems that arise when attempting to educate youth about contraception in a town without much access to the sorts of advertisements (both billboards and on television) and resources that are available to those in cities. The all-male teaching staff seemed primarily concerned with their inability to communicate effectively with their female students about contraception because of the social taboo that surrounds sexual topics, and cited a number of pregnancies in their classes as a result of inadequate education. Seeing the intensity of the problems being faced in the rural areas made it clear why so much focus is placed upon educating rural areas by NGO's and the media, but also made me wonder how individuals in cities, who theoretically have access to both male and female teachers, an abundance of information on contraceptives, and many more places to access them if they choose to deal with the same issues.

Between 1988 and 2008, the average number of children per woman in Ghana decreased from 6.4 to 4¹, a stark shift that many Ghanaian sociologists and demographers attribute to combined efforts of the government's UN supported family planning program and the extensive marketing and educational campaigns of non-profit organizations such as Planned Parenthood of Ghana (PPAG)². The country now boasts that "98% of all women and 99% of all men now know at least one method of contraception," an oft-quoted statistic that arises from the 2008 Ghana Demographic and Health Survey, conducted by the Ghana Health Service. Though Ghana has

one of the lowest birth rates in Sub-Saharan Africa and has already surpassed the goals set by the 1986 Conference on Population and National Reconstruction (Total Fertility Rate of 4.0 by 2010), a look at understandings of contraceptives at the local and individual level reveals significant differences in the ways that these attitudes are shaped and formed.

Through informal conversations with gender studies scholars and reproductive health workers in Ghana preceding the inception of my project, I found many people felt that while Ghanaian men and women are aware of contraceptive methods, men are less likely than women to hold scientifically-supported beliefs about how birth control methods work, and are more likely to think that birth control will prevent their wives from having more children (even after the device is removed or the woman stops taking oral contraceptives), will cause a woman's body to swell or become deformed, or will cause future miscarriages³. Because of my interest in gender and sexuality and the ways that peoples' lives are shaped by culturally reinforced gender roles, I decided to approach my topic from an angle where I could attempt to isolate gender as a factor that plays a role within the formation of an individuals' personal understanding of contraception.

In many ways, I realized that while I had been told repeatedly of the differences between men and women in lectures and in every conversations, I had hardly spoken with anyone to understand the ways that these 'differences' arise, and how they are perpetuated from parents to children or from societal messages to individuals through the media and schools. My goal for this project, with its specific focus on contraception and the ways that people of each gender form their ideas about it, was to illuminate for myself and others a great deal about gender construction in urban Ghana.

Methodology

Because I initially wanted to obtain a holistic set of opinions about urban areas of Ghana, I began preparing to conduct my research in two vastly different areas of the country that could still both be considered ‘urban’ – the cities of Tamale, in Ghana’s Northern Region and Cape Coast, which is located in the Central Region and borders the Gulf of Guinea. In many lectures from scholars who spoke to our group regarding Ghana’s history of colonialization and modern development, there was a large distinction drawn between ‘the North’ and ‘the South,’ based primarily upon differences in resources and infrastructure. The North is frequently referenced as being much more underdeveloped than most of the South, and though Accra and Kumasi are currently Ghana’s largest cities, Cape Coast holds much of the colonial influence and memory of Westernization that brought about many of the differences that currently exist between the North and the South. I hoped that looking at two areas that occupy such vastly difference spaces in the Ghanaian cultural imagination would help me to isolate distinctions that are unique to cities (as opposed to rural areas), as well as to look at the differences that continue to exist on a regional scale for a variety of reasons.

However, I contracted malaria during my journey to Tamale and for medical reasons, I decided to remain in Kumasi, which lies about halfway between the coast and the North in Ghana’s oft-heralded Ashanti region. Though I did not originally plan to do any of my fieldwork in Kumasi, I realized that staying in a single place for the duration of my project would provide me with a better understanding of the way that place factors into contraceptive understandings, and would also reduce the amount of time spent on travelling, finding resource persons in a new place, and adjusting overall to a change in environment and region. So from the 3rd of April to

the 3rd of May, I was able to plan and execute a revised version of my original project that took place entirely in Kumasi and the towns in and around the main city.

All of my work was conducted through and with the help of the PPAG (Planned Parenthood of Ghana) Young and Wise Center, which is located on the eastern end of the Kwame Nkrumah University of Science and Technology (KNUST), near the Bomso Gate. My advisor, Ms. Christina “Mimi” Acquah, more often referred to as ‘Auntie Mimi,’ is the current director of the PPAG Young and Wise Center, and helped me to further isolate my goals related to my project. She encouraged me to narrow my desired population group, which included deciding how many individuals I wanted to interview, how many people I wanted from each gender, the educational level of my population, age, and religious affiliation. Because working solely in Kumasi eliminated the regional variation component that I initially hoped would characterize my project, I decided that finding as much variation as possible within Kumasi’s borders would provide my project with just as much diversity in views, opinions, and backgrounds.



Figure 2.1 – KNUST Campus

After deciding that I would attempt to interview 25 men and 25 women of reproductive age from a variety of educational levels, religious affiliations, and socio-economic backgrounds, I took a few days to develop and refine the questions that I planned to ask each individual. With the help of my thesis advisor from my home institution, Dr. Carolyn Sargent, I narrowed in upon a list of twenty questions that I felt would provide me with the information I needed to answer my basic research questions, which were:

- How do men and women in Kumasi come to understand the major forms of contraception available in Ghana?
- Are there significant differences in the ways that men and women come to understand contraceptive methods, and are these differences influenced by region, religious affiliation, age, and socioeconomic level?
- How are these understandings either reinforced, shifted, or broken down by the Ghanaian government's reproductive health efforts, the work of NGO's focused on reproduction, religious beliefs, and social relationships?
- In what ways are NGO's and the Ghanaian government aware of the gendered differences in the understandings of contraceptive use, and what efforts are being utilized to combat existing misconceptions?

Because my main goal was to understand the way that individuals form their opinions on contraception, I utilized formal and informal interviewing as my primary technique. To me, this was the clearest way to see how people's opinions are shaped throughout their lives and what they consider to be the most important factors, as well as to have a basis for comparison across

groups. However, I was able to do minor amounts of observation in circumstances where my research assistants and I encountered and interacted with small groups of men and women on KNUST's campus. These chance encounters with rooms of three to six college students were extremely helpful because they allowed me to see the ways that some individuals interact with their peers about contraceptive use.

Because of the relatively informal nature of some of the interviews, I was often drawn in to participate as well. Many people used the final question (Question 20 – Do you have any final statements or questions?) as an opportunity to ask me and my research team about our opinions on contraception or about the efficacy and use of the methods that they knew little about or had only heard of on television or radio. Many people asked us about the truth of the rumors that they had heard regarding hormonal contraceptive methods and condoms. Though I often left answering these questions to the PPAG Peer Educators, who are trained to respond to these sorts of inquiries, this type of participation also inadvertently provided another lens into the ways that many people think about contraception. Quite often the questions that people asked at the ends of the interviews would contrast sharply against the confidence that they had displayed during the main portion of the interview about their knowledge of contraceptives and their use and mediums of efficacy.

The first portion of this study was conducted in the town of Anwomaso, which is approximately 10 km west of KNUST off the Accra-Kumasi Road. In Anwomaso, I visited a boarding house and interviewed five individuals, four of whom were students at KNUST, and one of whom was the house owner and not in school. The second portion was conducted in Ayudase, which borders the westernmost portion of the KNUST campus, where I interviewed 10 individuals who were all classified as out-of-school adults (non-tertiary graduates). The final

portion of the study was conducted in two of KNUST's dormitories, both of which were co-ed and housed students of varying ages, to provide for the widest amount of variety possible on the campus. I was able to conduct 32 interviews with current college students, and three interviews with out-of-school women who worked in one of the halls serving food and selling books and other items.

There were numerous limitations to this project. The sample group is not fully representative of urban Ghana, or even Kumasi, because though the group interviewed is diverse, it does not represent a perfect cross-section of the city. Though I was able to get an even gender split of 25 men and 25 women, there is an uneven distribution of college students vs. out-of-school students, Christians vs. non-Christians, and women vs. men within the out-of-school group. In a revised version of this study, I would widen the geographic distribution of this project and find a better method of incorporating out-of-school individuals into the project, because unlike the majority of the college students, they were often unable to commit to fully responding to a 20-question interview because of work and time constraints.

Many individuals did not consent to being tape-recorded, and while this was a personal choice that every participant has a right to, it made it extremely difficult to record exact responses to questions. Also, some of the recorded interviews are of poor quality because of background noise or improper placement of the audio recorder. Because of limited time and resources I was unable to use these interviews in the analysis for this version of the paper.

I also found it difficult to get exact responses from many of the out-of-schoolers, because most preferred to do the interview in Twi, which required my project assistants to perform the immensely difficult task of translating my questions and then back-translating answers into English. This made the interview process much more difficult and time-consuming, ironically,

for those who had the least amount of time. Often individuals would respond to questions with extended stories and descriptions that were difficult for my project assistants to translate in exact words, which resulted in many summarized versions of people's stories. Overall, there is less depth to the responses of the Twi-speaking individuals in my project as a result of this difficult translation process, rather than because they had less to say, which is an extremely faulty aspect of this project that is solely the result of an ineffective methodology. I would have liked to lessen this effect by having the interviews conducted solely in Twi and then translated into English at a later date. However, I realize that even then I would have missed the chance to ask the necessary follow up questions.

Another limitation that often presented itself in the interview process was difficulty understanding the questions asked. Through the trial-and-error process, I discovered ways to rephrase some of the questions that often confused interviewees, but the confusion, especially in the initial interviews, presents itself fairly clearly in some people's responses to some of the questions.

Finally, I think that my sample size could have been significantly reduced. While reducing the population would have certainly have simultaneously reduced the variety of responses and backgrounds of the project as well, I think that overall having a smaller sample size and being more selective about the group I wanted to approach would have provided me with a set of data that would have been easier to analyze and process. Though I find the set of data that I obtained very interesting and informative, I would have liked to have felt more comfortable looking at the ways that societal influence works to influence across and within groups, and it is very difficult to that using the data I have because there are so many different variables at work.

However, overall I am glad that I found such an assortment of individuals to participate in this project. Meeting with and listening to the stories of so many people from such an amazing variety of backgrounds, with so many different experiences with contraceptives was enriching and constantly exciting. Though there are many ways in which this project could be improved in the future, I found that many of the quirks and frustrations that I faced actually enhanced the quality and direction of my research in ways that I don't believe I could have previously foreseen or imagined.

Chapter 1: Bringing Up Birth Control:

The Formation of Contraceptive Understanding During Youth

Though Ghana's educational system mandates the incorporation of sexual education through its Religious and Moral Education (RME) curriculum from primary school to SS, respondents were initially exposed to information about modern contraceptive methods in a wide variety of ways. Most respondents recalled first encountering contraceptives in their Junior High School through teachers, though a few reported learning about contraceptives as early as in primary school and some as late as senior high school. This variety of responses seemed to reflect the structure of Ghana's sexual education system, where according to Eunice, a 21-year old student at KNUST, information about contraceptive methods is released "a little by a time" (Eunice, Personal Communication, 17 APR 2012). In lieu of providing young children with the full range of contraceptive methods available to them, it appears that schools and RME teachers tend to follow the "less is more" adage until students are in SS. Most respondents recalled being exposed to condoms in school, while most did not think that they were exposed to hormonal methods (birth control pills, Depo-Provera, IUDs, and the implant) through school. This phenomenon mirrors the experience of exposure to birth control methods on television and in advertisements – a clear majority of advertising is focused upon the male condom both on billboards and on radio and TV.

While almost all respondents remembered hearing about contraceptives in school, some were first exposed to them in other arenas. "Mama Janet", a married 40-year old woman living in Anwomaso, detailed her experience learning about contraceptive methods from within her own family:

My sister is a nurse, and since I was younger, she has been working in a nearby hospital (Manhyia Hospital in Kumasi) on family planning issues. So I have been able to get much information from her [about family planning methods] so that I was able to educate myself well. (Mama Janet, personal communication, 15 APR 2012)

Because Mama Janet had a family member who was already involved in family planning in a professional sphere, she was able to procure accurate information about a wider variety of contraceptives than she might have been able to given the limited resources provided through the RME courses. Years later, she continues to utilize her sister as a resource for her personal family planning needs, and has extensive knowledge about most of the hormonal methods. When she wanted to space the births between her children, she spoke with her husband and decided to procure birth control pills (colloquially referred to as ‘Secure’) through her sister. Mama Janet’s unique access to a person who was well-informed about birth control methods allowed her to feel comfortable making reproductive choices in her marriage that involved the use of hormonal birth control methods.

Most of the men and women interviewed did not have an experience that mirrored Mama Janet’s. Many respondents cited the lack of communication about ‘private’ matters within families as a reason for why most children learn about contraceptives in school rather than in the home. The number of respondents who learned about contraceptive methods, particularly condoms, through media formats such as television and radio was second only to the number of respondents who learned about contraceptives in school. For some, awareness of contraception was transmitted through viewing 30-second commercial spots over and over again, and others discovered various methods through public service specials that they watched on television.

Many respondents recognized that advertisements in particular were more focused on selling a product than on providing all of the information necessary to ensure unbiased, safe, and proper use of contraceptive methods.

However, some people found specific types of radio and television productions on contraceptives to be personally informative. For example, Eunice, a 21-year old student at KNUST spoke energetically about the way that she learned about contraceptives through a local radio program:

I heard about it on the radio, through Love FM, on David A's program. It's on everyday at two, and on Fridays they talk about health issues, and I remember one Friday I was listening with my friends and they brought a woman to talk [about contraceptive methods]. (Eunice, personal communication, 17 APR 2012)

From meshing what she learned in school with what she heard through the radio program, Eunice was able to provide a great deal of information about contraceptive methods and appeared to feel confident about what she knew. This confidence contrasted directly with the words of some of the individuals who could only cite commercials and advertisements as the basis of their knowledge.

While hearing about contraception in the family home was less common than learning about it through advertisements or in school, there were a few individuals who said that they learned about contraception from a sibling or from a parent. Bright, a 21-year old student at KNUST, said that he recalled learning about contraception from his father, but emphasized the abnormality of his experience:

My dad was a teacher, so it was spoken about in the home to me and my brother. But I don't think that is common at all, because of the culture of Ghana. [Most parents] would not talk about such things to their children. (Bright, personal communication, 15 APR 2012)

Finally, some of the individuals who were interviewed said that they heard about contraception through friends. This was particularly true for those who did not complete SS or college, potentially because the most detailed information about contraceptive use comes during the secondary years.

From comparing the responses of the men to those of the women, there were no immediately evident differences between the two groups on the ways that information about contraceptive methods are learned during youth. One of the reasons that there is no evident difference between the genders is because most people learn about contraceptives in school and from the television, where there is no difference in approach because both are meant to address a unisex audience.

However, when men and women who learned about contraception in the same manner are directly compared, there is a slight difference in experience between genders. For example, women who learned about contraception through family members were more likely to have been exposed to a wider variety of methods than men who learned about contraception in the household. Bright offered an explanation:

Like I said, you rarely find these things talked about in the home. But if it is, it is more likely that a mother or sister will talk to a girl than a father talking to a son. (Bright, personal communication, 15 APR 2012)

Kwabena's response and experiences of those who learned about contraception within the family illuminate some of the underlying differences that exist even in youth between male and female understandings of contraception. While it appears that the school system and television programming do not explicitly perpetuate differences in contraceptive understanding, existing gender roles in Ghanaian culture come into play when this information is relayed within the home.

Chapter 2: ‘You Only Know What You Know’:
Understandings of Efficacy and Mechanisms of Action

Knowledge of the various forms of contraception and opinions towards each method varied widely even between individuals of similar educational, gender, and economic backgrounds. Even though most individuals had been exposed to contraceptives through school, many were unable to name all or even most of the major forms available in Ghana (listed in Figure 3.10-3.15 in the appendix, with the exception of male/female sterilization, not pictured). While knowledge of the less common methods like the implant (Jadelle) and the 1- and 3- month injectables (Depo-Provera) was low overall, every respondent was able to name the male condom as a form of birth control, and nearly every respondent was able to identify condoms as the only form of birth control that protects users from both sexually transmitted diseases and infections as well as from unplanned pregnancy. This matches well with the results of the 2008 Demographic Survey, which states that “98% of all women and 99% of all men know about at least one form of contraception” (Gyimah), and also makes it fairly clear that this form of contraception is typically the male condom.

Knowledge of the other forms of contraceptives was quite limited in most cases, and seemed to relate directly to very specific and unique instances where an individual had gained access to a wealth of information about contraceptives, either formally or informally. For example, Mama Janet from Anwomaso gave the credit for her level of knowledge about contraceptives to her sister. She was aware of condoms, injectables, IUD’s, the pill, and sterilization, and fully approved of all of the methods except sterilization:

“You can think that you have all your children, but lose all of them, and then be unable to have more...it is permanent, and a woman should be able to have a birth later” (Janet Ablorh, personal communication, 15 APR 12)

Even though Mama Janet did not approve of sterilization for her own family planning needs, she was still able to offer “peace of mind when meeting with your partner” as a potential benefit for women and men who did choose to have vasectomies or tubal ligations.

While many individuals who were currently in-college or college educated could name methods of contraception beyond the male condom, full understanding of the mechanisms behind them and approval of each method seemed to vary drastically. Eva and Adua, both seniors at KNUST said that they knew of the male and female condoms, sterilization, pills, and the injectables. However, further questioning revealed the limited nature of their knowledge. “I’ve heard of the injectables, but I don’t know what it does,” Adua said when asked about which methods were most effective, while Eva felt confident that pills were the most effective. (Adua and Eva, personal communication, 17 APR 12) In response to a question about how her opinion on contraceptives has changed over the years, Adua says:

“We just know what we know. For the condoms, we know about it, but the injectables are on TV, but we don’t know about them.” (Adua, personal communication, 17 APR 12)

Eva and Adua’s responses to these questions are emblematic of one of the issues that accompanies television advertisements – a one-sided display of the facts. In this case, it is clear that while television and radio can make individuals aware of more forms of contraceptives than

they might encounter in school, they are often unable to provide them with the full range of information necessary for viewers to be able to make informed choices about the different contraceptive methods available to them.

Regardless of age, education level, and background, rumors and hearsay tended to play an extremely large role in the contraceptive understandings of those who did not have a personal experience with contraception. While those who used contraceptives or knew someone close to them who had were often exempt from this rule, many of those who chose not to use contraception or had only heard of distant friends or ‘friends-of-friends’ who used it were very likely to hold beliefs based on information passed through the grapevine from distant sources with whom they were not close.

One of the most repeated examples of this phenomenon was the idea that many of the hormonal birth control methods are negative because they will prevent women from being able to have children later. According to a study published in 1978 and many follow-up studies, this assertion has been scientifically unproven (Vessey et. al.). However, the Vessey study does assert that depending on the form of birth control and the woman’s body, fertility may be reduced for the three years following cessation of birth control, and it seems that this window of lessened fertility may be the cause of many of the negative discussions about hormonal birth control methods.

While the idea that a woman may have trouble conceiving after stopping a hormonal birth control method is couched in reality, the way that many respondents communicated ‘what they had heard’ showed a tendency to rely upon hearsay in developing their belief system about contraception, but also an understanding that their beliefs were founded on shaky ground. In a number of interviews, both men and women would say confidently that they had heard that it

was difficult to get pregnant after using hormonal methods, but then ask whether or not this was actually true in the portion of the interview process reserved for final questions and statements. This seemed to indicate that many respondents were aware that what they had heard might have less truth than they imagined and that they were willing to take advantage of educational resources about reproductive health (in this case, the PPAG peer counselors who were conducting the interview) when made readily available to them. Notably, many interviewees, especially on the KNUST, seemed hesitant or unwilling to come to the PPAG center for further education, but were very interested in asking questions in the comfort and privacy of their own space. This seems to mesh with the oft-cited idea that Ghanaian men and women prefer to keep sex and sexuality a private matter whenever possible.

While many men and women could cite examples from ‘friends-of-friends’ and acquaintances when speaking of the negative effects of various birth control methods, particularly related to hormonal birth control, some were fully unable to articulate what the negative effects were. In a conversation with a group of freshmen males from KNUST, and in many other interviews, the phrase ‘side effects’ was evoked without any clear understanding of what these side effects were.

Kojo: I approve of the condoms, but the others [hormonal birth control] have side effects.

Emmanuel: There’s something chemical, so those will certainly have a side effect.

Francis: Some are chemicals, and they will have side effects, so you should go for the ones with less side effects. [pause] Have you ever heard of someone actually getting side effects? Me, I haven’t heard of it. So we are talking about side effects and...[laughs].

(Emmanuel, Francis, and Kojo, personal communication, 17 APR 12)

In this case, each of the gentlemen participating mentioned side effects, but did not explain what the actual side effects were. Feeding off of one another, Emmanuel seems to attempt to reaffirm Kojo's initial assertion that there will be side effects present by citing the chemical nature of hormonal birth control rather than anything specific from his personal or educational experiences. Francis initially seems to intend to support his friends' statements, but upon further thought on the issue realizes that none of them are entirely sure what the actual side effects they are speaking of are. This seems to speak to the fact that while individuals make claims against hormonal methods of birth control for a variety of reason, often they are aware that these claims are rooted in less truth.

Once again, the role that gender seemed to play in an individual's knowledge was unclear based on these interviews. While those with more education seemed to know more methods of birth control, this knowledge was not always accompanied with more knowledge of how each method works or the positive and negatives of each method. Those who had a person in their lives who provided them with full amounts of information on birth control (such as Mama Janet) or who felt a need to fully educate themselves on birth control for personal reasons --such as Bright, who wanted to use birth control in his relationship while he finished a graduate degree (Bright, personal communication, 15 APR 12) --seemed to be the most informed, aware, and confident about the positives and negatives of contraceptives of all forms and types.

Chapter 3: “But They Don’t Like ‘Toffee Without the Wrapper’”:

Gendered Thoughts on Contraceptive Knowledge and Usage

The final portion of the interview was centered around understanding the ways that individuals come to conceptualize the way that gender factors into societal understandings of contraception. I was interested in matching the information individuals provided on their ways of understanding contraception with their thoughts on how other men and women tend to understand it, and the differences in the responses given to these questions in relation to the rest of the responses based specifically on an individuals’ personal history adds a unique dimension to the project.

One of the most intriguing ideas that I observed in obtaining the answers to the questions “How do individuals of your own gender and the opposite gender tend to think about contraception?” was that most of the respondents of both genders were convinced that their gender was the most concerned about contraceptive use – particularly for the college students who participated in the study. Husein, a senior at KNUST who also happens to be a PPAG peer educator, spoke towards this theory in his response:

“As a guy, my responsibility is high because responsibility is the most important [for me]. Females are most indecisive about whether or not they are ready to have children. Women get special orientation from [their] mothers – many women even tell their children what kind of contraceptives to use. Boys – [those from my] school and [my] friends – out of curiosity. We try to learn.” (Husein, personal communication, 15 APR 12)

Husein seems to believe that men in general must pay the most attention to contraceptives because men in general face a higher level of ‘responsibility.’ When asked about differences he notices about the ways that men and women come to learn about contraceptives, his response that women are more likely to receive information from mothers in the home mirrors the types of responses referenced in Chapter 1, but does not address the reality that for the most part, neither men nor women are learning about contraceptives in the home environment.

In the same vein, Eva and Adua, seniors at KNUST, seemed to feel that women were the most concerned about contraceptive knowledge:

Adua: [Men]don't care at all. Guys don't bother. Sometimes I even wonder if they think HIV is real.

Eva: Ladies always like to be protected.

Adua: Even if they [women] are not using [contraceptives], they are thinking about it.

(Eva and Adua, personal communication, 17 APR 12)

While neither seems to feel empowered in the way that Husein does about his ‘responsibility’ to provide protection, neither Eva or Adua agrees that men are likely to care about using contraceptives. Adua’s statement about women potentially wanting to use contraceptives without actually doing so seems to speak to the idea that women might not feel that they have the authority within their relationships to decide which methods, if any, to utilize for their own personal protection and comfort.

Being asked to isolate gender when thinking about contraception seemed to elucidate presumed differences between the genders that were not apparent in the personal response portion of the interview. For example, Steve, a mechanic from Ayudase, said that while he

doesn't personally use contraception, men generally choose to use it because they don't want to have too many children (Steve, personal communication, 16 APR 12). Nearly every respondent, regardless of gender, asserted that people choose to use contraception because they don't want to have more children, and in addition, many women, especially those who already had children claimed that men are usually the ones within relationships who want to have more children because women are the ones who feel the direct effects of childbirth and child-rearing. For example, Mama Janet of Anwomaso answered the questions on gender and contraceptive choice and decision-making with the following statement:

Women are more particular about contraception than men – they [men] expect women to space children, but don't need to know why or how [women do it]. Men like the natural feeling of sex. But women are also more worried about contraception because they find it difficult to conceive after stopping [hormonal birth control methods]" (Janet Ablorh, personal communication, 15 APR 12).

"This makes Steve's assertion that men in particular don't want to have many children, rather couples or women, particularly intriguing. Another mechanic, Fuseni, repeated a similar thought, saying that "men tend to be agreeable about using contraception" (Fuseni, personal communication, 16 APR 12).

Even when this theory did not prove true (in instances where women argued that men were the ones more focused on contraceptives, or vice-versa), both men and women seemed to rely on opinions of the other gender that were not supported by the responses provided in the initial portion of the interview process. Ivy, a student at KNUST, personally believed abstinence

to be the best method, and had never used any contraceptive methods before as a result. But when asked about gendered ideas of contraception, she offered the following:

“Guys force women to use protection because they don’t want to be fathers. [One of the negative effects of condoms is that] men don’t want to have “toffee without the wrapper.”
(Ivy, personal communication, 15 APR 12)

While Ivy doesn’t seem to personally believe that women are the ones who place the most focus on using contraceptives, her response is interesting because it seems to highlight two ideas that come up in the more typical responses: that men often have more control than women on contraceptive methods (regardless of who is more interested or concerned) and that the onus of bearing children when not ready is either the man’s or the woman’s rather than a responsibility of a couple.

The concept of “toffee without the wrapper” – or having unprotected sex/sex without a condom also came up during the conversation with Emmanuel, Kojo, Francis, and Enoch, all students at KNUST. “Some guys won’t use condoms – it’s like eating candy without the wrapper,” Enoch offered when asked about men’s tendencies related towards contraceptive methods and choice (Enoch, personal communication, 17 APR 12). While Kojo and Enoch felt that “ladies like condoms and tablets,” Kojo ended the discussion by saying:

“Sex is for marriage. So you as the husband should just study your woman’s cycle. That’s what Onan was told in the Bible.”(Kojo, personal communication 17 APR 12)

These statements display a variety of information about the ways that these particular boys see gender in relation to contraceptive decisions. There seems to be three modes of

understanding present in the situation – understanding on an individual level, and on a generalized male level and female level. While the boys repeated throughout the interview that sex was for marriage and should not be promoted to the youth (including college students), they did feel that women were more interested in contraception than men. However, when the circumstances were right (i.e., marriage), they believed that no artificial modes of contraception should be utilized, and that it was a man's duty to decide how birthing should be spaced by using the rhythm method.

Conclusion

Research rarely goes as predicted, and this project certainly fits into the vast number of research projects in existence that produced unexpected results or ended up highlighting something entirely different than the goals outlined within the initial research proposal. From the inception of this particular project to its conclusion, there have been a number of shifts in expected responses and actual outcomes that have given this paper and the data that shaped a unique tilt.

Going into this project, I expected that women would have more knowledge of contraceptives because of an active desire to seek out information on how to manage childbirth. In retrospect, one of the main reasons that my data did not confirm that theory is because my study population did not match up with the type of woman who specifically gains knowledge on contraceptives to prevent childbirth. Because college men and women dominated the study, it turned out that neither men or women were more likely to have any more knowledge than the other, except in specific circumstances, like that of Mama Janet who learned a great deal from her sister, or the married men who were still in school and needed to hold off on creating a family until after their degrees were finished. As might be expected, necessity of birth control plays a major role in the amount of knowledge that both men and women hold on the topic, but at times necessity is supplanted by special circumstances where an individual has access to a wealth of contraceptive knowledge.

One expectation that was confirmed was the increased likelihood of women passing down information on contraception to their daughters, which generally goes along with the idea that women are more likely to be concerned about contraceptive methods. However, this is only

gendered when related to males who received information about contraception in the home. Overall, the vast majority of respondents, male or female, did not receive any education about contraceptives in their homes, so this finding is relatively inconclusive with regards to larger understandings of gender on contraceptive knowledge.

The data gathered during the interview process and presented in the first two chapters generally contradicts the idea that gender plays a major role in the ways that men and women come to understand and continue to edify their knowledge of contraceptive methods. While this could indicate that contraceptive knowledge is not a particularly ‘gendered’ topic in Ghana, it seems more likely that the somewhat ineffective study design underlying these responses is contributing to this idea. A narrower and more in-depth version of this project, with modified questions and a well-selected sample group might add additional support to the idea that contraceptive knowledge is not strongly gendered, or might contradict these initial findings with a more specific report on the knowledge of a different sample group.

However, an entirely unexpected result of this project was the realization through the interview process that while individuals’ responses were not necessarily gendered, almost everyone *believed* in the presence of gendered understandings. While it was impossible to argue based on the answers from the sample group that men knew more or cared more than women, or vice versa, almost everyone gave more or less credit to a single gender when asked what the differences were between each gender’s understandings of contraceptives.

This result seems to speak towards the idea that men and women, especially those who are not married, rarely see opportunities to communicate freely with the other gender about contraceptives. This results in a great deal of ‘boys boys’ and ‘girls girls’ talk – a term used to refer to single-gender discussions about gendered concepts such as sex and sexuality, and

naturally, contraceptive use. Within these communities, rumors and hearsay are often perpetuated in a through-the-grapevine method about both men's and women's experiences about birth control. Because of the lack of in-depth education on the realities of contraception in schools and in most homes, individuals seem to rely on social means and their peers to gain the knowledge on contraceptive use that they desire.

Some of the most poignant results of this study came from the portion of the interview where individuals were invited to ask questions or provide their own 'final statement.' Nearly every individual, from all age groups, educational levels, and gender backgrounds wanted additional information on contraceptive methods, to check the 'correctness' of the knowledge they had displayed during the interview, or wanted to ensure that the study would result in additional education for the general population on contraceptive methods. While many individuals felt empowered after the interview as they became aware of how much knowledge they already held on a rarely discussed topic, many more wanted to fill in the gaps of knowledge they found they had during the interview. Adua, a KNUST senior, finished the interview by saying:

"This topic is not discussed. And it is awkward if you are a kid to be watching something in the house and it comes up. We only know the condom, so they should think about teaching the others [in school]." (Adua, personal communication, 17 APR 12)

While Adua's suggestion that education in school should be increased is well supported by the responses of other participants, the work that organizations such as PPAG do also provides another realm for informing youth and adults about reproductive choices. Because of the private nature of the topics, it seems that any sustained effort to increase generalized

knowledge of contraceptive methods should build upon the already existing social structure – ‘boys boys’ talk and ‘girls girls’ talk. As the PPAG peer counselors and I found quite unexpectedly through these interviews, meeting people where they are – in their dorms, communities, and homes – and providing them with a comfortable and judgment-free spaces to express themselves freely and ask questions without fear, and then allowing these discussion to trickle down through conversations can go a long way in changing the ways that individuals see contraception in their personal lives and in the larger spectrum of Ghanaian society.

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Appendix

Figures 3.10-3.15.

Modern Contraceptive Methods Common in Ghana. *(courtesy Google Images)*



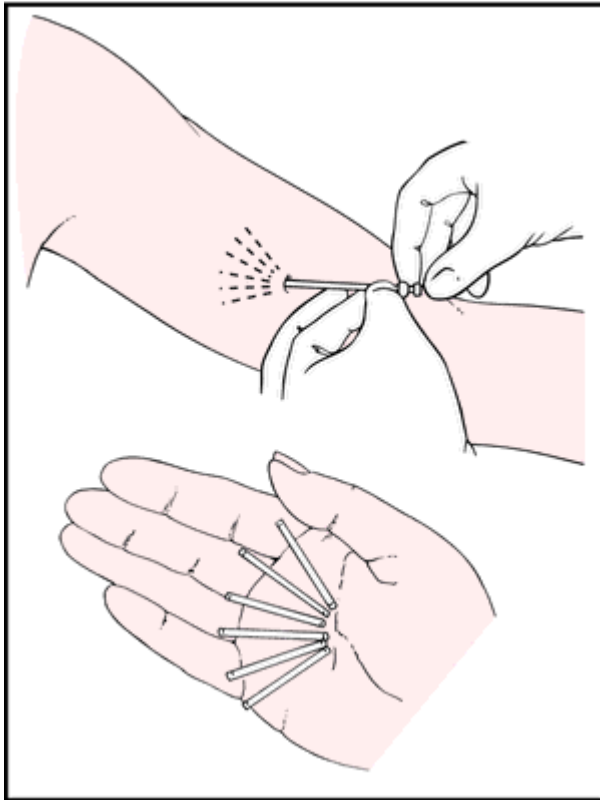
3.10 - Male Condom.



3.11- Female Condom (illustration)



3.12 – Mirco-Pill/Orals/ “Secure”



3.13 – Implant/ “Jadelle” (illustration)



3.14 – IUD (Intra-Uterine Device)



3.15 – 1 and 3-month Injectables.