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THE HIDE-AND-SEEK GAME: MEN'S PERSPECTIVES ON ABORTION AND CONTRACEPTIVE USE WITHIN MARRIAGE IN A RURAL COMMUNITY IN ZIMBABWE

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Summary. This paper is based on a study aimed at understanding the perceptions of men to induced abortion and contraceptive use within marriage in rural Zimbabwe. Two qualitative methods were combined. Men were found to view abortion not as a reproductive health problem for women. Instead, they described abortion as a sign of illicit sexual activity and contraceptive use as a strategy married women use to conceal their involvement in extramarital sexual activity. Men felt anxious and vulnerable for lack of control over women. In the absence of verbal communication on sexual matters, women and men resort to what are called here 'hide-and-seek' strategies, where women acquire and use contraceptives secretly while men search for evidence of such use. It is concluded that promoting women's sexual and reproductive health requires both short- and long-term strategies. The short-term strategy would entail providing women with reproductive technology they can use without risking violence. The long-term strategy would entail understanding men's concerns and the way these are manifested. In turn this requires the use of methodologies that encourage dialogue with research participants, in order to capture their deep meanings and experiences.

Introduction and background

This study explored the role of men in, and their attitudes and perceptions to abortion and contraceptive use. In particular, the study aimed at understanding the extent to which men regard abortion as a health problem for women. This paper presents three major themes derived from the data, including the views of men on abortion and contraceptive use, male labour migration, and the hide-and-seek strategies women and men describe in contraceptive use.

Mortality and morbidity from unsafe abortion is highly prevalent with an estimated 200,000 annual deaths globally, most occurring in sub-Saharan Africa (WHO, 1998a). In theory, this could be prevented by having only wanted and planned pregnancies, or by having access to safe pregnancy termination procedures. The crucial question is why unwanted pregnancies occur when preventive technologies supposedly exist, and unwanted pregnancy has increasingly become a major programme and policy issue for national and international agencies. This question cannot be answered fully in the context of this paper. However, the nature of services, the assumptions underlying programmes, and the technologies themselves play a role. Evidence indicates that available technologies may not be completely effective (Family Care International, 1998). But more important in this case is that even when technologies are available, women may have limited access to them because of service-related problems and gender power dynamics.

Service-related factors such as limited contraceptive options or choice, poor quality of service, and lack of information on side-effects are some of the problems often mentioned in the unmet-need debate (Bongaarts & Bruce, 1995; WHO, 1994). In many countries, women have one or two contraceptives to choose from. In Zimbabwe over four-fifths of women using a modern method have been found to depend on the pill (Guilkey & Jayne, 1997). This could perhaps explain why Zimbabwean women mention health concerns as a major reason for discontinuing contraceptive use (Government of Zimbabwe, 1998). A great deal of unwanted childbearing may therefore occur because women are dissatisfied with the limited contraceptive options available to them (WHO, 1998b), which exposes women to the risk of abortion. In Vietnam, a rather coercive two-child family planning policy depended largely on the intrauterine device, a factor which may explain the high rates of abortion observed there (Johansson, 1998).

Women also lack accurate information on which to make informed decisions (WHO, 2000). In the absence of such information, women develop their own information systems. In a rural community in Pakistan women were found to have misconceptions about the effects of contraceptives on their bodies (Winkvist & Akhtar, 2000), while women in Kenya were observed to circulate rumours about frightening side-effects (Ahlberg, 1991).

Besides the service factors, contraceptive use may be negatively affected by gender power inequalities, as described in the literature (Hardon, 1995; Hollos & Larsen, 2001). The role of gender in behaviour can be explained through the standard social science and evolutionary psychology models. Evolutionary psychology is concerned with behaviour-generating principles in the brain, which lead to selective adaptation to environmental pressures (Cosmides, Tooby & Barkow, 1992; Voestermanns &

Baerveldt, 2000). According to Cosmides *et al.* (1992), this occurs over a long period in human history. The social science model on the other hand holds that culture is an independent reality, bringing behavioural structures from the outside into the human brain, and that the mind is a general purpose machine which works on the basis of social construction of its content (Voestermanns & Baerveldt, 2001).

In evolutionary psychology, gender-specific behaviours may be held to fulfil specific functions such as survival and continuity. To the extent that gender within the social constructivist model is defined as an internalized way of seeing women and men that shapes their identities, perceptions and behaviour, and allocates social power, privileges and resources (Schwartz & Ruter, 1998; WHO, 1998c; Okin, 1989), it implies a complex interplay of psychological, biological, sociocultural and economic factors. In this context, the limitations of relying on one paradigm are acknowledged, and the position of Cosmides *et al.* (1992), who advocate conceptual disciplinary integration as timely, is considered. Having said this, however, the social constructivist approach has been chosen in this paper for two main reasons.

The first entails the contradictions of gender power now supported by increasing evidence in contemporary societies. Women have traditionally been presented as always being disproportionately subordinated, although acts of resistance by women have evidently changed, and are changing, their position. Furthermore, emerging evidence seems also to suggest that men's powerful position may also have been overplayed, and that their internalized gender behaviours may disadvantage them in ways not yet fully researched or understood.

Kaufman (1994), for instance, argues that contrary to popular belief, men have contradictory experiences of power. The male-constructed social and individual powerful image is paradoxically a source of enormous fear, isolation and pain for men because the internalized expectations of masculinity are impossible to satisfy or even attain. The personal insecurities from the failure or threat of failure to make the masculine grade may propel in men rage, isolation, self-punishment and aggression. This is a feature of men's world now being highlighted in increasing numbers of studies. In India, according to Chandiramani (1998), men calling a help-line on sexual problems expressed anxiety over their ability to satisfy their wives sexually. Such a failure would make the wife look elsewhere for sexual satisfaction, which in turn would be seen to reflect on the husband's inadequacies.

World Bank-supported research using a participatory research approach (Deepa *et al.*, 2000) has illuminated from interviews with large numbers of women and men from many different countries how men respond to unemployment or loss of livelihood. Unable to play their socially defined role as breadwinner for their families, men have expressed humiliation and anger. Large numbers of men are reported to resort to alcohol consumption, drug abuse and other self-destructive behaviour. Moreover, unlike women, their internalized meaning of being a man prevents unemployed men from taking menial jobs. In the area of HIV/AIDS, increasing evidence similarly links the transmission of the virus to masculinity. The circumstances in which women and men contract HIV/AIDS are different but gendered (UNAIDS, 1999; Foreman, 2000), where women are vulnerable because they have limited opportunities to protect themselves, while men take risks because this is how men are expected to behave (Foreman, 2000).

The second reason concerns the assumptions underlying policy programmes, particularly their limitations and failures in achieving the expected goals. The assumption that technological fixes, for example family planning directed at married women, would reduce fertility and induce demographic transition and socioeconomic development ignores a number of things. It ignores the complex global power relations that maintain poverty in poor countries, but more significantly in the context of this study, it ignores gender power dynamics, the ways in which they manifest themselves, and the contradictory male power or its impact on the sexual life of couples within marriage. Even when gender has increasingly become a major policy issue, nationally and internationally, a major gap is still the silence at the relational level, the family or the private sphere (Okin, 1989).

Understanding gender dynamics, and the specific ways they are manifested at the relational levels where men and women interact, communicate and negotiate for sex, would form a sound basis for developing more effective approaches to involving men in reproductive health programmes, now recognized as being important (WHO, 1998d). To gain such understanding, however, has methodological implications. It may require going beyond the knowledge, attitude and practice (KAP) surveys widely used to evaluate family planning programmes, even though they have been found to have limitations in their assumptions, conceptualization and design (Hauser, 1983; Bleek, 1987). Qualitative methods were thus used in this study for their appropriateness in capturing the deeper meanings, as well as men's personal experiences in abortion and contraceptive use, within marriage.

Research process and methods

This paper is based on data from a sociological study that is part of a larger ongoing collaborative research programme on reproductive health between three medical university institutions in Zimbabwe and Sweden. The current study was explorative and generated information on men's perspectives on abortion and contraceptive use. As a qualitative study it does not therefore claim to be representative in the traditional sense, nor was it concerned with prevalence of abortion and contraceptive use. Rather, the observations made indicate that men and women may experience these phenomena in ways not already identified and that more elaborate studies are needed. Moreover, the shortcomings of using specific data-gathering methods (Helitzer-Allen, Makhambera & Wangel, 1994), for example in this case a dominant voice in focus group discussions (FGDs), were evident in this study. A combination of FGDs and individual interviews, as well as different research participants (Sandelowski, 2000), was used in order to explore different dimensions and perspectives of the research question, but also to validate observations.

The study community and context

The study was carried out in a rural community in Chiredzi, a district in south-eastern Zimbabwe bordering Mozambique and South Africa. Chiredzi District is administratively divided into three communal areas and 30 wards (Government of Zimbabwe, 1992). The study site was 60 km north-west of the district's headquarters

in Ward 14 of Sangwe communal lands, chosen for its accessibility. A highway linking Chiredzi to another border town, Mutare, and the capital city, Harare, cuts through the study area. Women from the villages sell fruit and vegetables at the bus stops and market centres along the highway. This rural setting compared well with an earlier hospital-based urban study within the same research collaboration (Mbizvo *et al.*, 1997). Chiredzi is also one of the districts with the highest maternal mortality figures in the country (Government of Zimbabwe, 1998), another factor considered important in a study of abortion.

The area is too arid for subsistence agriculture. Large-scale sugar and tea commercial farming comprise the major activities, offering employment for the local population. Male labour migration to the local mills and plantations and also to neighbouring countries, mostly South Africa, is a common feature of the study area. Men from the area migrate to South Africa leaving their wives and children behind for long periods of time. Most of the migrants enter South Africa illegally. They thus have problems getting secure employment and accommodation. Employers also exploit their illegal status by underpaying them. This means they have difficulties making financial remittances to their families.

Male labour migration implies that women assume entire responsibility for childcare and family welfare. Women thus engage in tasks such as moulding bricks, farm work, beer brewing and vegetable vending.

A family planning programme is being implemented by the Zimbabwe National Family Planning Council in collaboration with an international non-governmental organization. Local young men, commonly known as male motivators, have been trained to motivate and encourage contraceptive use. They also distribute contraceptives to complement the services of the local clinic. A survey was conducted to evaluate this programme (PLAN International, 1999). According to the survey, men in the communal areas of Chiredzi marry at an average age of 23 and women at less than 18 years of age. The mean age at first sexual intercourse is 19 for men and just under 18 for women. The total fertility rate is 7·4, much higher than the national average of 4·3 reported by the Government of Zimbabwe (1997). Fifty-five per cent of women want more children than they already have. Contraceptive prevalence is reportedly high with 60% of men, compared with 54% of women, saying they currently use contraceptives. The contraceptive prevalence compares well with findings of other health surveys for the country (Government of Zimbabwe, 1997). Of the contraceptive methods currently used in the three communal areas surveyed, the pill was reported by 36% of men, and 23% of women, and the injectable by 17% and 11% respectively. Use of the condom was reported by 32% of men compared with 4% of women. Ninety-seven per cent of women in Sangwe reported that their partner approved of contraceptive use, and men from the same area were reported to have higher willingness to use contraceptives in the future (79%) compared with 44% of women. There was no information on abortion.

Data collection and sampling

Data were collected during 1998–99. Since abortion is a sensitive issue about which little is known, an 'emergent design' in the tradition of qualitative research

Table 1. The data collection process, sample and study population

Research process	Data collection method	Sample	Participants' characteristics
Stage 1	FGDs	4 with 35 male participants	Group 1: age 18–20, all never married Group 2: age 20–26, all married Group 3: age 25–35, all married Group 4: age 38–65, all married
Stage 2	Individual interviews	4 women	All married Aged 30–40
Stage 2	Individual interviews	10 women	All married Aged 17–50 Husbands currently in SA
Stage 3	Individual interviews	10 men	All married Age 25–40 Worked in SA
Stage 4	Individual interviews	19 men	16 married, 3 single Age 19–65 5 had worked in SA

generally (Maxwell, 1996), but also as in specific qualitative methods such as grounded theory (Glaser, 1992) and ethnography (Agar, 1996) was used. This entails making decisions on sampling as the research progresses and new issues are generated in what is referred to as 'theoretical sampling' (Maxwell, 1996). Data analysis in this context ran concurrently with fieldwork in a reflexive and iterative process (Marshall & Rossman, 1989; Pope, Ziebland & Mays, 2000).

Approval to conduct the research was granted by the Medical Research Council of Zimbabwe and the Research Ethics Committee of the Medical Faculty, Uppsala University, Sweden. Local authorities and politicians were informed about the study and their consent was sought before commencing fieldwork. Participants received a full verbal explanation of the study and their consent was sought; they could decline and withdraw from the study should they wish, and confidentiality was ensured.

Table 1 presents a summary of the research process including the sampling procedure and data collection methods. Since the focus was to obtain perspectives of men, the research process started with interviewing men using FGDs. The study started with FGDs because these allow participants to discuss sensitive issues without revealing their personal experiences (Farquhar, 1999). Moreover, FGDs were chosen because, as argued by others (Barbour & Kitzinger, 1999; Helitzer-Allen *et al.*, 1994), they are appropriate for exploring a sensitive topic about which little is known, and for providing suggestions for individual interviews. In this context, FGDs were also expected to provide insights not only into the meanings, but more importantly the idiom system and language commonly used by men and the community to describe abortion and related issues.

Although at this point the aim was to reach men in the research community, an attempt was made to select participants in order to maximize variation (Maxwell, 1996) in their experiences and views based on age and marital status. Participants in the FGDs were selected with the help of the family planning male motivator, who was familiar with all homesteads in the area and family members in those homesteads. Clearly biases could arise from using family planning motivators, and to minimize the problem of the researchers being mistaken for family planning agents the male motivator only acted as a field guide, not as an interviewer. Four FGDs were conducted, three comprising married men and one unmarried men. A total of 35 men aged 18–65 years participated in the FGDs.

Surprisingly, abortion as a women's health issue was of limited concern to the men interviewed. Instead, they viewed abortion as a sign of women being involved in illicit sexual activity. It also became clear that labour migration created anxiety, with the men feeling vulnerable due to a lack of control over their wives' sexuality.

These two observations, or what in ethnographic terms is referred to as a 'rich point' (Agar, 1996), were important in the decisions on subsequent sampling and data collection methods. From the way men discussed abortion as a sign of infidelity, it became imperative to include married women in part to validate or dispute the views expressed by men, but also to gain insights on perspectives of women and their experiences of abortion and contraceptive use. Four married women were interviewed at this initial stage. The women mentioned migration-related tensions similar to those described by men. The following interviews explored in more depth the view of men and women on migration and the sexual and reproductive lives of couples. With the help of the family planning male motivator and a female village health worker, ten men who at one time or the other had migrated for labour purposes, and ten women whose husbands were living and working away from home, were identified and interviewed. Additionally, nineteen men were finally selected to represent experiences of men in this community in general. In total, 43 men and women were interviewed individually, and at the end the picture of the power dynamics at the relational level had crystallized.

Data analysis

The taped interviews and FGDs were transcribed and translated from Shona to English by the first author. The first and the last authors then read and re-read the transcripts, marking the text segments with relevant meaning units. Codes and concepts were developed around the relevant meaning units identified, and transcripts were searched for further relations between new aspects of data and the concepts already found.

Findings

This section presents three themes derived from the data indicating that married men are more concerned with sexuality in the case of abortion than they are with women's health. The first theme is about the views of men on abortion and contraceptive use within marriage, and in particular their feeling of vulnerability for lack of control

over female sexuality. The second theme is labour migration, which was observed to increase anxiety and vulnerability in men, while the last is about the 'hide-and-seek' strategies women and men describe they resort to in contraceptive use.

Men's views on abortion and contraceptive use within marriage

Men viewed abortion as a sign of extramarital sex by the wife. The way this view was expressed in the FGDs moreover suggests that men are ashamed to admit that abortion is common within marriage. Initially a participant in a group discussion with older men, aged 38–65, indicated that abortion was not common in the community. This view was, however, contradicted by other participants who suggested that abortion was indeed common, even within marriage, and that it is because of this that men are embarrassed to admit it, as one group participant said:

> '. . . when you hear us say that it happens among the young girls, it is a way of making it easier for us to talk. It happens very often within marriage. It is common to hear that the wife of so-and-so has had an abortion. When we say the problem is among the youth, we are just trying to avoid the truth and the embarrassment . . .'

A second participant added that abortion is a big problem within marriage:

> 'Yes, among our wives we have a big problem [group laughter], a very big problem. You see, we are talking about the youth. I want to clarify that it's not about the youth. It's about the older women, our own wives, the ones with whom we have given birth to these school youth.'

The view that abortion is common in the community was echoed in the individual interviews with men as well. But abortion was described as secretive, and men knew of it only when a pregnant woman appeared later without the pregnancy or the baby, or when a pregnant schoolgirl returned to school without the pregnancy. Men referred to this as 'a pregnancy that disappeared'. They nevertheless indicated that women were likely to know about abortion because they often assisted each other to abort in secrecy. There were two reasons mentioned by men why women would not disclose abortion or abortion-related illness. Women were said to anticipate violence from their husbands, and to fear being forced to disclose the man supposedly responsible for the pregnancy.

Abortion was, however, said to be declining because women are now increasingly using contraceptives to avoid pregnancy. This trend seemed to make men more anxious because it was then more difficult to detect extramarital sexual activity or a wife cheating on her husband. A FGD participant from a group of married men aged 38–65 said amid agreement:

> '. . . these days cases of married women aborting are rare, because of family planning. What is common today rather is the use of these family planning pills. It has become less common among married women to abort . . . It is now difficult to tell whether a woman is cheating because she is on family planning pills . . .'

The data from this study, however, also suggest that men may not be completely opposed to contraceptive use within marriage. For example, when men feel they have the number of children they desire, they said they may accept contraceptive use. They did, however, express concern that contraceptives would be open to abuse, especially

when a husband was away, as illustrated in the following quote from an interview with a 50-year-old married man who had never migrated:

> '. . . when I do not want any more children, I may request the health worker to tie my wife's womb. . . But then those things are not good . . . If you go far away, and leave your wife behind, she starts to *hura* (prostitute) and you will not know what is happening . . . If it is your wife, you may not suspect. But even if you did, you can't see anything . . .'

Men also seemed aware of the value of the condom as a preventive measure for both disease and pregnancy, but similarly feared it can be open to abuse. According to a 35-year-old married man who had returned from South Africa:

> '. . . a condom is a good thing. If you use it the right way. It is not bad because it prevents many things . . . It becomes bad when, say you are a married woman, and your husband is far away, and then you decide to have other relationships . . .'

Men's concern with contraceptive abuse seemed to be a reflection of their own sexual behaviours and double standards. Those who had migrated to South Africa, for example, admitted having had sexual relationships with other women and having fathered children. Men were therefore concerned that their wives would similarly enter into extramarital sexual relationships to revenge or get even, as one man aged 27 explained:

> '. . . a woman is a woman. Even when you are around she can engage in those bad activities . . . As a man, you may go to work even for a period of say two weeks . . . and your wife then decides she also should do as you do while out there . . .'

Women moreover indicated experiencing the double standards of men through continuously being made pregnant as a strategy to make a wife too tired to want to inquire about the husband's extramarital sexual affairs:

> '. . . men tell each other, ''if you find your wife asking about your movements too much, make her pregnant, then she won't ask''.'

The anxiety and vulnerability among men seemed to be more intense when away from home. The following two sections focus on the concerns of men, their anxieties and vulnerability during migration, as well as their strategies for checking their wives' use of contraceptives during their absence.

Labour migration and vulnerability among men

Male migration is, as mentioned above, a common feature of life in the study area, often involving long separation of spouses. Interviews with women indicated that some husbands had been away for up to 5 years or more, and in such cases some of them had entered into sexual relationships with other men. A middle-aged woman illustrated in an interview the general situation of women left over a long duration of time:

> '. . . you see the woman lying there? . . . She is my daughter-in-law. Say my son just leaves . . . with the aim to work . . . and while she remains here we treat her like our own child . . . so that other people in the village do not get the idea that she is suffering . . . We try to cover up by giving her food and clothing . . . But as time goes . . . there comes a time when we also can see she is not free, she is tied down . . . and she misses something . . . But then I do not have my son's

address to write to him . . . She also does not know it. So she stays on just like my daughter, until her brains [gesture pointing backwards] . . . Now when a person's brains turn backwards like that, not even myself can change her . . . then he comes back and finds his wife pregnant.'

When away from home, the feeling of lack of control among men becomes more intense also because they are unable to support their families financially. As indicated earlier, once in South Africa, men may be poorly paid or unemployed. Furthermore, they may enter into new sexual relationships making their meagre resources less accessible to their families back home.

Use of contraceptives when the husband is away was strongly considered by men as a breach of what is locally known as *kutenderana* (agreement), which should be the basis for contraceptive use. Use without *kutenderana* is thus interpreted by men as an intention to conceal extramarital sexual activity. A FGD participant in the group of married men aged 25–35 stressed this point:

'Those pills are only supposed to be used while I am at home. When I am not at home, what is the purpose of using them?'

Another participant in the same group emphasized amid group agreement that when a man is away, a wife has no reason to prevent pregnancy:

'By simply being in Joni (Johannesburg) for work . . . it means I have saved us having another child '

These accounts indicate that while men may see abortion and contraceptive use in terms of increasing female sexual freedom, contraceptive use for women may instead fulfil one of many survival strategies. When women need contraceptives, they see no reason to tell their husbands, whom they consider as impediments. Two widowed co-wives (age 38 and 40), who were interviewed together, elaborated on the reasons why women use contraceptives secretly:

'. . . our experiences . . . have taught us to take the pills without the husband's knowledge than ask for permission.'

These conflicting views and experiences therefore invoke a hide-and-seek strategy as a way for women and men to deal with such conflict. The actual hide-and-seek strategies are discussed in the following section.

The 'hide-and-seek' strategies

Women described the ways they acquire and use contraceptives. They, for example, fetch contraceptives from a clinic situated at the market centre as they do their usual grocery shopping. At home they have various ways of hiding and using contraceptives secretly. For instance, they may hide the pills in the bag of maize meal currently in use, and take them as they prepare the family meals. This was mentioned as the most commonly used strategy, described as *kudyira muupfu* ('eating in the maize meal'). Women also hide the pills outside, sometimes under a stone. They then wake up before their husbands and take the pills. Sometimes they hide the pills in their daughters' rooms, which men by tradition are not allowed to enter unless absolutely unavoidable. Other women hide the pills in the roofs, or a female friend is used for safekeeping.

Men then described their searching strategies. On return home, men search for contraceptives or contraceptive packets. An open packet was said to be critical evidence of contraceptive use. A married FGD participant said amid agreement from the other participants:

> 'When I come home . . . I open my house – you know it is my house – only to find those pills hidden. Then I ask myself, ''What is this? I seem to recognize it? Oh, it is pills. What is the purpose of these pills? Oh, these are for family planning. So what should I do?'' By the time my wife comes home, I have already discovered those pills. They are actually open and in use. Then I want to know why she was using them.'

Another middle-aged man who had never migrated demonstrated what a migrant husband should do on return home:

> '. . . the first thing . . . he should check is whether there are any pills around . . . Once he finds the pills, he knows ''Oh, this woman has been doing something. Why did she take these pills? She cannot just take pills with nobody around . . . She is supposed to be alone and not sleeping with anyone''. . .'

Another strategy described by men was to arrive on a date different from the one the wife was told. A 27-year-old married man, who had been away over a stretch of 3 years, said:

> '. . . you should not alert her . . . you should announce a wrong date. Then you arrive on another day, or you skip a month or two. Or when you say month-end, you arrive the beginning of the next. You see, it is just trying to see whether something may come out . . .'

A third strategy described is to arrive unannounced or late at night. It seems even men who had never migrated were aware of these strategies. A married man aged 30, who had himself never migrated, explained:

> '. . . so you arrive at night . . . If a person does something bad she relaxes and thinks you are not coming any more. So you make a surprise arrival. You arrive in the dead of the night . . . around midnight or one o'clock . . . That is when evil things happen . . . You make sure you delay a little. Most get caught in that way. One man was hit with a machete. He was caught unawares . . .'

Another 27-year-old married man who had been away for the previous 8 years dramatized during an interview how the arrival should be done to ensure that the husband did not miss anything:

> '. . . you should not just get in without a plan . . . stand outside, ask her to light the lamp and then start getting in, slowly. When you get in don't look at her, start by looking around, because another man may bump on you while escaping . . . your wife will then deny there was a man . . .'

Men also search their wives' bags and the wardrobe for traces of contraceptives or clothes of other men. They also inquire from friends and relatives about the wife's behaviour during their absence, or look for new sexual skills. For men, if the wife had not been having sex with other men, she should be difficult to penetrate.

Threats and physical assault were mentioned as yet another strategy to ensure that the wife never attempted to have extramarital sexual activity. A 28-year-old man who had worked in South Africa said:

> '. . . I tell her, . . .' ''once you do that I slash your throat''. Knowing how I have become hardened by the crime in South Africa, she just will not dare . . .'

Contraceptive use is therefore critical in gender violence. Men indicated that when they discover contraceptives, they might beat their wife. The women interviewed elaborated on this and described a *hondo* (commotion) that occurred in the villages in the early 1990s. A storm in the area blew and exposed packets of contraceptives hidden in the roofs and under stones. Mothers and their daughters were beaten as they accused each other of owning the contraceptives. Another woman in the village was reported to be nursing wounds inflicted after being beaten by her husband over use of contraceptives.

A wife may also be sent back to her parental home if discovered to be using contraceptives. One of the women interviewed narrated a case where a woman had been sent back to her parents after her husband discovered contraceptive pills in the roof of her daughters' house. The woman was not welcomed by her family:

> '. . . at home her brothers questioned her. She said, ''The pills are mine''. And they asked, ''Why did you use them when your husband had said he did not like them?'' And she answered, ''Ah! What would I do when I was bearing many children? I was weaning a child before enough breast-feeding time.'' She was tried and the husband demanded a fine . . .'

Finally, men said they consulted traditional healers. There was, however, disagreement on this strategy with some men arguing that traditional healers would never disclose involvement of a wife in extramarital sexual activity since this would split families. Traditional healers are nevertheless consulted to prevent a wife being attracted to other men.

Discussion

This study aimed to understand the views of men on abortion and contraceptive use. It should be seen in the context of the current debate and policy developments concerning the need to involve men in sexual and reproductive health programmes. This debate is a response to the increasing realization that family planning programmes are performing badly, largely due to the failure to involve men (Ahlberg, 1989; WHO, 1998e), or to address the issue of gender dynamics.

These data suggest that men do not view abortion as a health problem for women in the way expected. Instead, they see it as a sign that women are involved in extramarital sexual activity. The data moreover indicate that men inhibit contraceptive use, which they similarly associate with illicit sexual activity. The inhibition of contraceptive use contradicts findings of a survey in the same area showing that 97% of women said their husbands approved of contraceptive use. However, the finding that men inhibit contraceptive use is not unique to this study. Other studies (Bongaarts & Bruce, 1995; Winkvist & Akhtar, 2000; Nzioka, 1998) have made similar observations. Neither is the finding in this study, that men see abortion and contraceptive use as an indication of extramarital sexual activity on the part of the woman, unique. Male anxiety over contraceptive use and female sexuality has also been reported elsewhere. A study in northern Ghana suggests that men's anxiety over use of contraceptives stems from their fear of loss of control over their wives (Bawah *et al.*, 1999). Adongo *et al.* (1997) similarly report that among the Kassena-Nankana in Ghana, men commonly state that contraceptive use allows women to conceal extramarital sexual activity.

The anxiety and vulnerability described by men in this and other studies therefore suggest the futility of approaches that focus on women, or concentrate on changing male attitudes through promotion of awareness and knowledge of family planning methods. Instead, contraceptive use or non-use should be viewed alongside the dynamics of heterosexual relationships, the ways in which these are manifested at the micro-relational level, the social construction of sexuality and the meaning of sexuality for women and men. This, however, calls for approaches that give voice to the different stakeholders, in this case women and men. The qualitative method and research participant triangulation used in this study enabled the micro-level or everyday experiences of women and men, and their specific struggles in contraceptive use, to be obtained in ways survey methods may not.

A major finding in the current study is the micro-level hide-and-seek strategies used by women and men. The hide-and-seek strategies indicate that there is little verbal communication between husbands and wives. This is similar to observations made in a community study in Pakistan, where women reportedly used contraceptives secretly for fear of violence from their husbands (Winkvist & Akhtar, 2000). Another study in Ghana by Salway (1994) found that only 35% of wives and 39% of husbands had any discussion on family planning with their spouses during the previous year. In the absence of verbal communication, women can only guess what their husbands think about family planning (Toure, 1996).

The form of silence and secrecy in abortion and contraceptive use observed in this study may have a number of implications. In terms of women's health, the silence and secrecy imply that abortion and related complications and even death may occur without men knowing the cause. Furthermore, although abortion in this study was not seen as a health problem for women, the observation that men were aware of what they described as the 'pregnancy that disappeared' may also imply that women commonly have late abortions, which has far reaching consequences for women's health.

The silence furthermore conceals the forms of resistance of women to male power, or how they exercise their agency. The clandestine strategies used by women and the anxiety and vulnerability expressed by men dispute the popular view that husbands determine childbearing in the family (Loewenson, Edwards & Ndhlovu-Hove, 1996), and that women's position in patriarchal families is essentially weak (Hollos & Larsen, 2000). Without disregarding the vulnerability of women and the male violence within patriarchal structures, emphasizing women's powerlessness risks concealing other capabilities of women, which can be the basis for promoting women's health (Campbell, 2000). Additionally, the view of an all-powerful male conceals the contradictory experiences of power in ways such as described by Kaufman (1994). As Angin & Shorter (1998) conclude in their study of fertility decline in Turkey, men and women are capable of revising and subordinating structures and relationships around them.

In conclusion, this study points to two policy planning strategies. The first, a short-term strategy, would entail provision of reproductive technology that women can use without risking male violence. The second, a more long-term strategy, would entail a gender analysis that aims to understand and build on the dynamics at the relational level, the way masculinity expectations are experienced by men and can be

changed, and women's agency and their forms of resistance, as part of improving women's sexual and reproductive health.

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