

FROM
CAIRO
TO
KAYORO

*Bringing Reproductive Health
to a Village in Ghana*

A PERSONAL ESSAY BY
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This is a millennium tale of two locales whose names are pronounced the same: one is Cairo, Egypt, the site of the 1994 International Conference on Population and Development; the other is Kayoro, a settlement in northern Ghana. It is important to understand the effect that the events in one location have had on those in the other. I had a first-hand chance to see the Cairo–Kayoro axis in January 1998.

The Cairo Conference was a large and important gathering that has had a lasting impact in many countries. What made this conference different from others were the people who participated in it and the document that they produced after many meetings and much effort—the Cairo Consensus. There were two groups of major players. One consisted of 183 country delegations, many of them participating for the first time in such a conference, with 3,500 government delegates (80 percent of them men), four heads of state, seven prime ministers, and five vice presidents. Serving as a counterpoint and sometime conscience were 5,000 representatives of non-governmental organizations (NGOs), 80 percent of them women, and over 300 women's groups from around the world. This conference marked the first time that NGOs were recognized as influential players; some countries actually included NGO representatives in their national delegations for the first time.

In Cairo, two major messages: reproductive health care and the empowerment of women

Two major messages were crafted at the Cairo Conference—the importance of reproductive health (including family planning) and a new emphasis on the empowerment of women as a centerpiece of social, economic, and demographic development. Although much media attention was focused on high-profile religious confrontations over parts of the Consensus, there was remarkable agreement by all delegations on most of it.

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Most delegates concurred that the goal of family planning services should be to support individuals’ and couples’ reproductive health and reproductive rights.

The acceptance of these two major areas of agreement meant that those of us who work in the population field have had to examine and sometimes revise our agenda. While recognizing that contraception and family planning are necessary components of any reproductive health program, Cairo signaled that the world had to complete the paradigm shift with respect to the way contraceptives should be provided: no longer to achieve any national target or community goal but to offer a range of good-quality services to meet the specific needs of the individual. This meant great change for some programs, less for others.

A related recognition was that the achievement of other demographic goals, such as reducing rapid population growth, required improving the situation, educational levels, and status of women around the world. This understanding was particularly vital for women in poorer countries who cannot effectively exercise their reproductive rights or achieve reproductive health without greater bargaining power within their families and with their partners.

Fine words and fine thoughts, to be sure. But how do these new concepts stand up to the reality test of a remote and poor village?

**In Kayoro: very poor, isolated, male dominated,
and pronatalist**

The other “Cairo”—Kayoro—is a settlement located in one of the poorest areas of the world, in northern Ghana close to the border with Burkina Faso. It is an hour’s rough jeep ride on unpaved roads from Navrongo, where the Population Council has been working with the Ghanaian government to study health and related issues since 1994. Navrongo is the only town nearby with electrification, telephone service, and paved roads. Kayoro is

a patrilineal/patriarchal society headed by a chief, who is paramount along with nine other chiefs. The Kayoro population is traditional, agrarian, rural, isolated, and impoverished. Over 80 percent of adults are illiterate. Kayoro villagers are definitely among the one billion people globally who live on the equivalent of less than \$1 per day.

In Kayoro, male dominance is assured by marriage custom and one-third of families are polygynous. Many women marry in their teens and there is a large age difference between spouses. Women are viewed—and view themselves—as the property of males. Domestic power relationships assure male control over family resources and health-seeking decisions; in fact, all decisionmaking abilities are vested in males. Religion is traditional and includes ancestor worship. Soothsayers control the access to ancestors. Of course, only men can consult soothsayers.

The society is pronatalist and women have on average more than five children in their lifetime. With high levels of infant and child mortality, about one in four children do not see their fifth birthday. Infectious diseases and diseases of malnutrition are prevalent. Although immunization has had its successes, many can remember measles epidemics that wiped out all of the children within certain families. Children are seen as one of the main purposes of life, essential to carrying on the ancestral lineage. Women without children are seen as being punished by the gods and ancestors. Wifebeating is common, expected, and sanctioned.

In such a poor society, can integrated reproductive health and family planning services be made available? Can they reach women who have little or no personal mobility? In such a strong traditional society, where marital and kinship customs diminish the reproductive autonomy of individuals, what kinds of policies are needed to legitimize family planning services? How can women with so little power exercise the reproductive rights Cairo said was their birthright?

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How relevant, then, is the Cairo Conference to a woman of Kayoro?

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The Cairo Conference called for the assurance of reproductive health, including all those aspects that could affect the ability of women and men to engage in healthy, enjoyable sexual relationships with or without the intention of procreation, and for a woman to carry a pregnancy to term and give birth in good health for both mother and child. Information about and voluntary access to safe and effective contraception must be imbedded in the larger concept of reproductive health.

Since 1994, Ghana's Ministry of Health has played a key role in providing an answer to this question through a multi-year longitudinal study on the delivery of a series of primary health care inputs, including family planning services. The manager of these activities is the Navrongo Health Research Centre, a research station established within the Ghanaian Ministry of Health to conduct research, develop innovative programs, and demonstrate new policies to the government. Originally established as a site for research on the impact of vitamin A supplementation and malaria bednets on mortality, the Navrongo Centre has been funded by the Rockefeller Foundation, FINNIDA, and USAID to develop a broad-based experimental initiative on family planning and reproductive health. This reproductive health research program has been developed with technical assistance from the Population Council. Consistent with the Cairo thinking, Ghana's integrated program offers free birth delivery, postpartum care, attention to reproductive tract infections, and family planning services. The government is seeking to improve these services in rural areas, where they are unavailable, unused, or underused, and seen as foreign and unfriendly.

Nurses on motorbikes

I began to understand the unique quality of the Navrongo experiment when our group followed one of the commu-

nity health nurses to households in the surrounding villages. She carried a portable basic health care and family planning kit strapped to her motorcycle. She provides drugs and contraceptives, gives advice about breastfeeding, and keeps track of immunizations. She is seen as a health worker, not a family planning worker. The head of a family of ten sons mentioned repeatedly how glad he was that she came to his compound. Integrated services, or at least the provision of a range of health services, is a tenet of the Cairo Consensus. I could well believe one of the Navrongo Centre's researchers who said that "one nurse on a motorcycle outperforms a whole health center."

Men in the Navrongo region, including Kayoro, are very jealous of their power prerogatives over women (they have, after all, purchased their wives in good faith). The men were concerned, above all, with the answer to the question, "Will you, the health care provider, give family planning to my wife without my permission?" When the answer was "yes," many men expressed their fears and concerns that the service program would liberate women from their personal control.

Village conclaves about health issues

The Navrongo team addressed these concerns by working with the chief and elders to educate men about the benefits of family planning and to encourage their participation in the program. Several other steps have been taken to bring the men of Kayoro into the picture: *durbars*, or traditional village conclaves, were organized around child survival and family planning health messages. People were encouraged to speak out and express their concerns. They did and they still do. Support began to grow from the top of the village hierarchy on down, and eventually some families began to accept the concept of family planning. The team also sought out women's voices. This alone represents an enormous change in terms of women's roles and their ability to be heard.

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Something a little more unconventional has also been done. The deceased ancestors have been brought into the picture and were asked their views on family planning via the soothsayers. To the surprise of the project staff, the elders have reacted with openness and readiness to consider this a promising development for the health and wellbeing of the village as a whole.

Although only 4 percent of Kayoro women were using a contraceptive method at the beginning of the integrated program, many women were very interested in family planning; 30 percent thought they might adopt a contraceptive method “soon,” mostly to space births but also to limit family size. However, they indicated in focus group discussions that they did not feel their own views on family size were germane, children being a community good and wives a purchased property. Male opinions and preferences dominate reproductive decisionmaking, although research also shows that there is little discussion or dialogue about family planning. Secrecy about family planning and lack of discussion are the norm in this society.

Women choose contraception

Change slowly is coming to Kayoro. Over a 15-month period, despite the fact that a woman's decision to use family planning services could be met with violence and social opprobrium, the number of contraceptive users climbed several-fold to about 20 percent of married women of reproductive age. Depo-Provera has been the method of choice by most, with health records kept by the community health nurse so that husbands will not find them. However, when a husband discovers that his wife has been using such a method, it is not uncommon for the nurse to be confronted with the wrath of his disapproval.

Why have some women opted for contraception in spite of the risks? The answers are complex and not fully known. But research in the Navrongo Centre area indicates that one reason some women choose contraception is as a substitute for the traditional means of fertility reg-

ulation—long postpartum coital taboos and spousal separation. Undoubtedly, the innovative design of the family planning services has played an important role. Women prefer the injectable contraceptive because it is so convenient, delivered right to their doorstep along with other crucial health services. The project also has paid extraordinary attention to integrating information and service-delivery work into traditional systems for village communication and governance. Family planning services appear to have been legitimized in the eyes of men and male leaders because the program actively sought their participation.

Female excision decreases

Collaborative research also has focused on adolescents in this region of northern Ghana. As education has increased for adolescents—particularly for girls—traditional sexual and reproductive patterns have begun to change. The incidence of early marriage has started to decline. Increased education is starting to exert a negative effect on the practice of female excision—female genital mutilation—another form of violence against women. Research has shown that 77 percent of women in the region have been excised, but the practice now is more common among women over 24 years of age than it is among those 17 years old. Girls who do not go to school and are not excised are teased and tormented. But among schoolgirls, it is the ones who are excised who are teased. A harbinger of change? One would imagine it to be so.

The Cairo Conference's broad definition of reproductive health includes prevention of and protection against sexually transmitted diseases. In remote Kayoro, fear of being infected with the HIV virus that causes AIDS ought to be of more concern. As a result of massive rainfalls or droughts, the men of Kayoro leave at various times in the year to find seasonal employment; the women are left in the compound, often without permission to wander outside their homes. The level of HIV/AIDS is felt to be low

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but the risks are high, especially because of the seasonal out-migration of men, who may have a number of sexual encounters while away. In addition, the traditional practice of abstaining from sexual relations after childbirth for long periods of time—sometimes up to two years—frequently is justification for men taking extra partners.

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Conversations about disease prevention are rare

Disease control related to intimate relationships is a subject that is often avoided in this society by health workers and by women and their partners. More than 70 percent of women have not discussed family planning with their spouses; it is unrealistic to expect them to raise the question of disease prevention. The chances of a woman protecting herself against sexually transmitted diseases are exceedingly small. Women's lack of empowerment makes it unlikely that they will initiate conversations about using condoms, the only method available to prevent the spread of sexually transmitted diseases. The benefit of condom use for disease protection is not yet very usable information for the women of Kayoro village. As mobile health workers gain experience, they may be able to counsel women on how their choices of contraception should be influenced by their own determination of likely reproductive risk. Council research in several countries has shown that women are very capable of making changes and choices that reflect assessment of their personal risk. Giving women a method they could use to protect themselves from sexually transmitted diseases—without their partners' permission—has been a priority for Council researchers. Clinical trials will soon get under way testing a microbicide women can apply vaginally to assure protection from an array of STDs. The Council is working on two versions: one would prevent, the other permit, pregnancy.

The broad definition of reproductive health also includes the concept of safe motherhood—prevention of maternal mortality associated with pregnancy and childbirth. While maternal mortality rates have plummeted

around the world over the past four decades, they are still exceedingly high in the developing world—over half a million maternal deaths each year. In parts of East and West Africa, for example, the risk of maternal death during pregnancy or childbirth is over 1,000 per 100,000 live births. The rate is lower for Ghana, an estimated 740 maternal deaths for every 100,000 live births, but this is still much too high. Research has shown that an important factor in improved maternal health is the presence at delivery of a trained attendant with midwifery skills. In the Navrongo region, conversations have begun on how to immediately recognize an obstetric emergency and treat it, and there is also talk of a motorized tricycle to serve as an ambulance.

Research at the Navrongo Centre suggests that the mechanisms for increasing use of family planning and related services are not the same in this part of Africa as they are in other regions. While important, convenient distribution of contraceptive supplies to meet individuals' needs will not necessarily be successful in societies where men are dominant and women lack bargaining power. Instead, programs should be designed to foster social legitimacy for family planning in the community by reaching out to groups of men and women, providing program information, and fostering communication.

Moving Kayoro through the fertility transition

Slowly, but surely, the people of Kayoro are beginning the fertility transition to low birth rates that has already occurred in most areas around the world. Once rare, contraceptive use is now practiced by one in five women; total fertility was 5.5 before the Navrongo experiment began and declined to below five births per woman in the year following my visit. In the spirit of Cairo, the Navrongo Health Research Centre is offering family planning within a broader range of reproductive health services.

How quickly the fertility transition progresses depends on three key factors. The first is a reduction in unmet need

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for contraception. Failure to use family planning results not only from lack of access to high-quality contraceptive supplies and services, but from lack of knowledge, fear of side effects, and disapproval by family and society in general. These reasons explain why more than 100 million women in less developed countries are not using contraceptives in spite of the fact that they would prefer to space the next birth or have no more children. In the developing world as a whole, one in five women have an unmet need for contraception, and in some countries the number is much higher, for example in Pakistan, where close to one-third of women have an unmet need for contraception. In Kayoro, the power relationship between women and their husbands is so disparate that women do not even raise the subject because they fear spousal disapproval.

Desired family size is another determinant of the pace of the fertility transition. In most traditional societies of Africa, women typically want at least five or six children, but as development proceeds desired family size is expected to decline. Using Asia as an example again, there have been remarkable changes in desired family size in the region. In 11 Indian states very low levels of ideal family size are reported—from 2.1 to 2.6 children per family. Similarly, there has been close to a 40 percent drop in desired family size in Bangladesh over the last two decades. In Kayoro village, a substantial number of men and women believe that the number of children they have is God's gift, and almost none want a smaller number. But the chiefs are beginning to change their minds and the elders are reserving their opinions. This acceptance of the desirability of small families will be fostered by improvements in the health and education systems and by the introduction of some measure of social security. It means making steady gains on issues regarding the status of women; in Kayoro village, this is not going to happen tomorrow but it will happen some day.

Even if fertility were to decline quickly in Kayoro, population growth would continue for several more

decades because of population momentum. The third factor determining the pace of the fertility transition, momentum is caused by the large numbers of young people entering their reproductive years. In the developing world as a whole there are almost one billion 10-to-20-year-olds, the largest such cohort of adolescents in history. If every woman in the developing world had access to and used contraception and each family had only 2.1 children (the number required to replace them), the developing world's population would still increase to 7 billion by the year 2100 from the current level of almost 4.8 billion. This example shows how powerful a demographic force population momentum represents.

The powerful impact of population momentum

Indeed, momentum will account for nearly all future population growth in countries where fertility already has reached replacement level—Sri Lanka, for example—and for well over half of the projected population growth in India and Bangladesh. In Kayoro village, momentum will account for less, because it will be overshadowed by high numbers of children desired and a great unmet need for contraception. But with half of Kayoro's population under the age of 15, momentum will nevertheless be a major factor. Momentum can be influenced by a package of investments affecting mainly girls that will delay the age of child-bearing and promote spacing of children. Investments that could have an impact on momentum include an emphasis on education; income-earning activities, especially those related to micro-credit programs; and gender training.

It should also be noted that small differences in the post-transitional fertility numbers will make enormous differences in the population picture in the long run. For example, if India's fertility stabilizes at about half a birth below replacement, population size a century from now would be about where it is now—0.9 billion, instead of the 1.9 billion presently forecast. If fertility were to stabilize at half a birth above the replacement rate, the popu-

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lation in 2100 would be 3 billion. Modest efforts to reduce fertility have large effects on future growth.

Many see the Cairo Consensus approach as downplaying traditional demographic concerns. In some ways it does. The Population Council's research over four decades strongly suggests the need to address demographic concerns through a broad range of programs that encompass but are not limited to family planning. High-quality family planning and reproductive health services help to reduce unplanned and unwanted childbearing. This unmet need, of course, is exactly where Kayoro women are starting, but they have a long way to go.

It would be a great mistake, however, to measure the fertility transition solely in quantitative terms without paying attention to improvements—or lack of them—in the status of women and gender equity in Kayoro.

Women's lives also must improve

With a narrow focus on fertility alone, it is possible to achieve a fertility transition without improving women's lives at all. Improvements in women's status, however, will create favorable conditions for fertility decline and better reproductive health. These essential strategies, endorsed at Cairo and at the subsequent Beijing women's conference, will contribute to gender equality while creating conditions favorable for smaller families:

- Increase educational attainment, especially among girls: The availability of mass education changes the value placed on large families and encourages parents to invest in fewer but “higher-quality” children, capable of entering the emerging labor markets.
- Improve child health and survival: No developing country has had a sustained fertility decline without first having experienced a substantial decline in child mortality.
- Invest in women and provide them with economic prospects and social identities apart from motherhood: Improvements in the economic, social, and legal status

of girls and women are likely to increase their bargaining power, giving them a stronger voice in family reproductive and productive decisions.

A final conversation with the chief of Kayoro

Let me end my description of how Cairo affected Kayoro village by recalling a conversation with the chief. He is a traditional chief and greets visitors wearing a red cap with a pointed straw hat over it. Accompanied by the elders of the village, we are summoned to his presence. The straw hat is removed once the ceremonial greetings are finished. He asks us to make our remarks to the elders. He is young and his election as chief by Kayoro village was a surprise.

He points over his shoulder to Burkina Faso and the Sahara desert beyond. We talk of the rains that, once again, did not come. El Niño is mentioned. Life could hardly be more basic than it is for his people. We let him choose the topic. And he says, “In the times of our fathers, a man could have 20 children,” meaning twenty sons. “Today a man cannot do this because the family will not prosper. Our people must change.” The elders nod. The visitors are astonished. The dust swirls down from the desert to the north. Between the women and the chief, the demographic change will begin. And Cairo does touch Kayoro—but there are many miles to go.

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