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Fraught with ambivalence: Reproductive intentions and contraceptive choices in a sub-Saharan fertility transition

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Abstract. Demographic studies that search for signs of fertility transition in sub-Saharan Africa rarely examine the complex gamut of individual aspirations and misgivings, hopes and frustrations, failures and triumphs that accompany the emerging declines of fertility rates in the subcontinent. This study draws upon qualitative data collected in peri-urban areas of Maputo, Mozambique's capital and largest metropolis, to explore contradictory meanings and feelings surrounding changes in fertility intentions and contraceptive choices. It argues that although changes in these two aspects of reproductive life are interrelated, they are predicated on distinct types and configurations of external pressures and psychological apparatus, which is often manifested as a puzzling disjunction between fertility preferences and contraceptive use. This disjunction can be further reinforced by persistent gender divisions in reproductive views and strategies. Informal social interaction plays an important role in building societal consensus over fertility matters, but because such interaction deals with reproductive intentions and contraceptive use through largely different mechanisms, it may also help accentuate the intentions-contraception disjunction. This study's findings therefore call upon both researchers and policymakers to attend more closely to the multidimensionality of fertility transitions in sub-Saharan societies and specifically to the complexities underlying such popular notions as "unmet need for family planning," "spacing" versus "limiting" births, or "spousal communication" on reproductive matters.

Keywords: Contraception, Fertility, Mozambique, Sub-Saharan Africa

Introduction and conceptualization

In fertility research reproductive intentions and contraceptive behavior are commonly viewed together as two aspects of the multifaceted process of fertility change. Typically, studies have attempted to link the two by assessing how well contraceptive use matches reproductive goals (Feyisetan & Casterline 2000; Bongaarts 1992; Akhter & Ahmed 1992; de Silva 1991; Westoff 1990; Schutjer et al. 1986). From the standpoint of applied research in particular, reproductive intentions, conveniently measured by survey questions on desired fertility and desired timing of future births, have been relevant mainly as predictors of contraceptive demand and adoption, and through contraception, of

fertility outcomes. The influential concept of ''unmet need for family planning'' is a direct product of this matching exercise. The empirical evidence, however, has been inconclusive and has led some researchers to question the relevance of the ''unmet need'' concept and measures (Desai & Alva 1998; Yinger 1998), others to reassess the role of contraception and family planning programs in fertility change (Moultrie & Timæus 2003; Bledsoe 2002; Bledsoe et al. 1994; Pritchett 1994), and yet others to look for ''new types'' of fertility transition (Caldwell et al. 1992).

Seldom, however, have demographers been willing to scrutinize more thoroughly the meanings and cultural relevance of the concepts and measurements with which they operate. In this study, I explore what reproductive intentions (to which I also refer interchangeably as preferences and desires) and contraceptive use actually mean to women and men in a typical sub-Saharan peri-urban society and how they situate these often conflicting meanings within a changing cultural frame of references and ultimately apply them to their actions.

My analysis revolves around three main arguments. First, drawing mainly from Watkins's research in Kenya (Watkins 2000), I argue that in a rapidly changing social and reproductive environment, where the pronatalist inertia of rural tradition and the antinatalist pressure of modern life collide, individual fertility intentions, even though increasingly oriented toward smaller families, are tentative and often contradictory. Contraceptive use, although rapidly spreading, remains experimental, and individual users are often more concerned with contraceptives' negative side effects than with their effectiveness in preventing unwanted pregnancies (Castle 2003). Second, I propose that even though reproductive intentions and contraceptive use are linked conceptually and practically as parts of a broader reproductive strategy, individual considerations and social mechanisms that guide each of them may differ, which often surfaces as a confusing mismatch of reproductive desires and contraceptive use in survey data. My earlier research (Agadjanian 1998a) suggests that this theoretical and empirical confusion may stem from differences in factors underlying the formation of reproductive intentions and of contraceptive choices: whereas the former are conditioned mainly by what conventionally is considered economic factors, such as the perception of costs of children and childbearing, the latter are more of a cultural process predicated largely on informational resources and receptiveness to technological innovations, especially in settings where pecuniary costs of contraception are negligible.

And third, I posit that both the formation of reproductive intentions and the adoption of contraception are influenced by informal social interaction outside the marital unit. A growing number of studies point to the crucial role that social interaction plays in the process of reproductive innovation (Kohler 2001; Montgomery & Casterline 1998; Kohler 1997; Rutenberg & Watkins 1997; Valente et al. 1997; Bongaarts & Watkins 1996; Montgomery & Casterline 1996). My own earlier research (Agadjanian 2001, 2002a) suggests that this role is particularly significant in a transitional society, that is, a society where new fertility attitudes and contraceptive practices have already emerged but have not yet taken root, and where therefore different reproductive regimes coexist. This social interaction is gendered: social contacts and networks of men and women are largely separate, which tends to reinforce gender differences in attitudes toward fertility limitation and contraception (Agadjanian 2002a). Reproductive preferences and contraceptive choices are therefore continually renegotiated through intense – even if often indirect – gendered social interaction. Yet elaborating upon the conceptual distinction between "social influence" and "social learning" proposed by Montgomery and Casterline (1996), I also argue that social interaction affects reproductive preferences and contraception through different mechanisms: while preferences are shaped largely through "social influence," contraceptive decisions are affected mainly through "social learning."

Data and methods

I develop these arguments using the example of Maputo, the capital and the largest city of Mozambique. This analysis draws upon the qualitative data that my research team and I collected in the city's peri-urban areas between 1998 and 2003. That fieldwork was part of a multistage project on reproductive dynamics and social change, which integrated both survey and qualitative components. The bulk of the qualitative data used in this analysis was gathered in 1998. The fieldwork included individual in-depth interviews and focus group discussions conducted separately with women and men in Portuguese, Mozambique's official language, and Tsonga (Ronga-Shangana), the Bantu lingua franca of Southern Mozambique. All study participants were either married or had permanent partners. We carried out 84 semistructured individual interviews with women and 60 interviews with men; all interviewees were unrelated to one another. We held a total of 20 focus group discussions: 12 with women and 8 with men,

all of them also unrelated. Although we obtained more information from women, the data supplied by interviews and focus groups with men are sufficient to analyze gender differences in reproductive matters. The individual interviews and the focus group discussions with both women and men revolved around the same issues: reproductive and contraceptive experiences, perceptions, preferences, and expectations. Both the individual interviews and focus groups placed special emphasis on the role of informal social interaction in reproductive and contraceptive changes. In more recent fieldwork stages, which also included semistructured qualitative interviews, we added a focus on HIV/AIDS, trying to link reproductive preferences and choices to prevention attitudes and behavior. Through the entire duration of the project, the in-depth interviews and focus group discussions were supplemented with ethnographic observations and countless casual conversations with Maputo residents of both sexes.

Although these qualitative data are not generalizable statistically, their usefulness should not be underestimated. In comparison with survey data, qualitative information paints a more realistic and comprehensive picture of reproductive complexity: it captures misgivings and ambivalence surrounding fertility intentions and contraceptive use that usually go undetected in surveys, and depicts the process of continuous, even if subjectively unimportant, reassessment of cultural norms, material constraints, and opportunities, and of own and others' reproductive and contraceptive experiences (Agadjanian 2003).

Socioeconomic and reproductive changes in Maputo

Typical of large and fast growing sub-Saharan cities in many respects, Maputo represents at the same time a condensed reflection of the unique political and socioeconomic vicissitudes of Mozambique's recent history. Throughout the past three decades it was transformed from a racially and socially diverse and divided colonial capital into a hotbed of socialist socioeconomic and political experiments in the second half of the 1970s and the first half of the 1980s, and then into the center stage of structural adjustment reforms that were launched in Mozambique in the second half of 1980s. As other sub-Saharan cities, Maputo has experienced a huge inflow of migrants from rural areas that turned into a stampede of refugees in the worst years of a brutal civil war that ravaged Mozambique between the late 1970s and 1992.

The radical privatization and other market- and pluralism-oriented reforms that gathered momentum in the country throughout the

1990s and into the 21st century have been particularly advanced in the capital. However, despite Mozambique's impressive macroeconomic growth, poverty there remains endemic (Mozambique 2003). In fact, our study's interviews indicate that people perceive their material conditions in the last dozen years as worsening, even if this generalized perception may reflect the rising consumer aspirations fueled by the glittering abundance of goods and services on the market rather than any real decline of living standards. Also importantly, unlike the poverty of "empty shelves" of the socialist years, the current poverty of "empty pockets" has a clear monetary measure allowing individuals to evaluate and compare different consumer options. Besides, the market reforms have produced a small but conspicuous economic elite, whose exorbitant wealth accentuates the poverty of the majority.

The monetization of urban and household economy has greatly accelerated the process of transformation of traditional rural-origin institutions and ways of life, a process otherwise typical of any urban milieu but somewhat retarded in Maputo by the egalitarian socialist policies and the nearly universal misery of the war years. The ecological constraints characteristic of urban life, combined with the forceful proliferation of market capitalism and the growing exposure to cultural globalization, have led to a rapid erosion of bridewealth-based marriage, of extended family obligations and expectations, and of traditional gender hierarchies. The inertia of social conscience, however, continues to portray these institutions as legitimate and normal, or at least as ideal. The coexistence of conflicting social and cultural codes and expectations creates an ambiguous sociocultural atmosphere in which seemingly incompatible attitudes and preferences are easily reconciled. These dynamics have important implications for reproduction: although reproductive innovations are spreading rapidly, ambivalence about the relative and absolute value of childbearing, quantity versus quality of children, and about benefits versus costs of contraception persists. Novel reproductive preferences and practices are not perceived as a radical and unconditional rupture with the past and therefore may be easily accepted and adopted. However, due to the same illusion of cultural continuity, even if accepted and adopted, these preferences and practices often remain tentative, circumstance-driven, and potentially reversible.

As is typical of large sub-Saharan cities, Maputo has been in the forefront of the emerging fertility transition in Mozambique. Thus, at the time of the first general census conducted in 1980, the national total fertility rate (TFR) estimate stood at 6.4 children per woman,

while the corresponding estimate for Maputo was 5.7 (Mozambique 1995). The second national census conducted in 1997 put the national and Maputo TFRs at 5.9 and 4.0, respectively (National Institute of Statistics n/d). The Demographic and Health Survey (DHS) carried out in the same year produced very similar estimates – 5.6 and 4.0 (Gaspar et al. 1998). (At this writing, data from the 2003 DHS are not yet available.) The 1997 DHS also captured a wide gap in contraceptive use: 28.5% of married or cohabiting women in Maputo were using modern contraceptives at the time the survey was conducted, compared to only 5.1% nationwide (Gaspar et al. 1998: 61).

These comparisons, however, conceal considerable within-city differences, particularly the gap between the more urbanized and westernized central part of the city, popularly known as the "cement city," and the vast semirural peri-urban belt that constitutes Maputo's "reed city." Thus, according to a demographic and health survey conducted in 1994, the total fertility rate in the cement city was estimated at 3.8 children, whereas in the urban districts constituting the reed belt the total fertility rate was a much higher 5.4 (Lopes & Santos 1995, 36). Figure 1 shows age-specific fertility rates by urban district computed from the number of children born in the 12 months preceding the 1997 census. District 1 roughly corresponds to the cement city, Districts 2 and 3 form its immediate suburban fringe, and Districts 4 and 5 lie farther out. The generally more westernized and educated District 1 clearly stands out, especially with respect to fertility in the two youngest age groups, conveying the familiar trend of

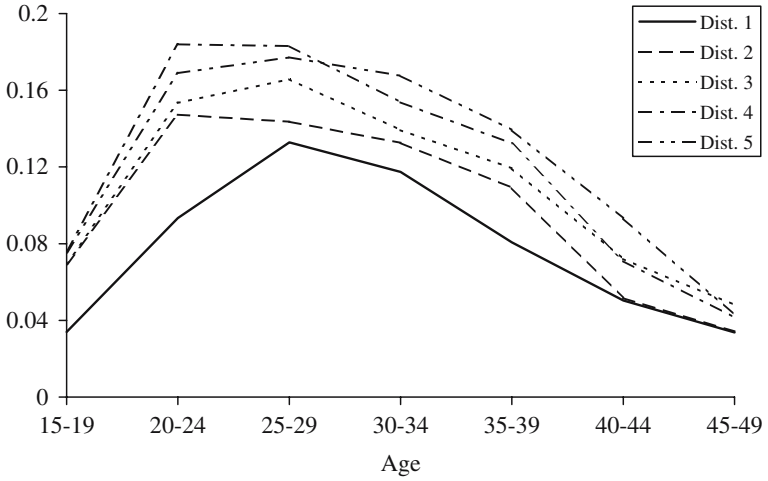

Figure 1. Age-specific fertility rates by urban district, Maputo, 1997.

delayed entry in childbearing. While looking at these district-level data it is important to keep in mind that all the districts are integral parts of the same, relatively compact settlement, and only a half-hour bus ride separates Districts 1 and 5, a ride that thousands of commuters take on a daily basis.

This significant within-city heterogeneity in fertility reflects considerable differences in ways of life between the city's cement and reed sections, which were magnified by massive war-triggered migration to the city from rural areas in the second half of the 1980s and early 1990s, as most migrants settled in the reed suburbs (Ibraimu 1994). Interestingly, according to a 1987 survey of reproductive behavior, Maputo had the highest contraceptive prevalence in the nation, but at the same time, over one-third of its female residents of reproductive age did not know any contraceptive method (Monreal 1991: 7.2). Although this extreme imbalance disappeared by 1997, when the first DHS was conducted (Gaspar et al. 1998: 54), much of the disparity between the cement core and the reed belt persisted.

Reproductive intentions

The complexity of reproductive attitudes and preferences reflects the underlying diversity of conflicting social norms, cultural codes, and behavioral models. Women and men come under simultaneous pressure from different sides: the traditional expectations of many offspring, religious teachings on procreation, economic constraints of urban life, indigenous and imported family models, and the official family planning establishment. Because reproductive attitudes and preferences often have to be attuned to mutually incompatible social and cultural standards, fertility intentions are often ambiguous, tentative, and easily changeable. Depending on individual characteristics and circumstances, certain preferences may prevail, but they may also be altered as these characteristics and circumstances change. The following quote from a women's focus group discussion illustrates these ambivalent views on fertility regulation:

> I am really thinking about family planning because life is difficult. That's why having children [these days] is a sin, while in the old days it wasn't a sacrifice. I think that we should seek family planning to shut ourselves, but so that it will not be forever, because it's our duty to procreate and fill the land. But because of the life we now live, we suffer with the kids to the point that we

> begin to think family planning is best, while it's not so at all, because without children there is no family. If you give birth to five children, they will be your family, ten children—they are your family... But because life these days is so difficult, we find ourselves in a situation of not wanting more children... But this is due to the fact that we are suffering [trying to provide] for their clothes, food, school, and everything else.

The heavy burden of economic "conditions" is the primary argument for fertility regulation. The perception of unacceptability of large families in the current economic situation transcends educational and ethnocultural boundaries, although the levels of desired fertility may vary by schooling level and degree of urbanness. In most cases, however, fertility limitation is accepted reluctantly and rationalized as a temporary adjustment to the current economic constraints. Children and childbearing are still seen as vital to family well-being and status, and the benefits of fertility limitation are believed to last only as long as the economic straits persist. "Now it seems that people don't want to have more children but it is not so," noted a 30-year-old woman, "... we want more children, but because of the [economic] situation we can't." The interviewees invariably complained of economic hardships but did not necessarily see them as universal. "There are those who do well in their lives and those who don't," reasoned one female focus group participant, "those who are well [materially] need more children but those who are as bad as I am do not need any more." Thus people still see fertility limitation as a painful sacrifice driven by individual conditions and circumstances. This helps them reconcile their individual choices with the traditional value of large families, as pronatalist attitudes need not be completely abandoned in order to take steps in controlling individual fertility.

Interestingly, the depth of current economic hardships is further underscored by the idealization of the past. With respect to childbearing, popular reasoning tends to confuse the idealized traditional rural living with the mythologized colonial urban "prosperity," when money was scarce but prices were low; in neither type of circumstances is fertility limitation perceived as necessary. But even the scarcity of the socialist years is seen as less conducive to fertility limitation than are modern times when everything seems to have a price tag. In addition to unemployment, low wages, and incessantly rising consumer prices, our study participants emphasized the costs of children's education: although those costs are still not exceptionally high, they underscore

the changes occurring since the socialist years when education was virtually free. This particular attention to children's education also reflects the perception of its growing importance for social advancement, a phenomenon observed in other parts of sub-Saharan Africa (Makinwa-Adebusoye 1994; Caldwell 1980). Education-related and other costs of children seem so high that they typically outweigh parents' concerns about sources of support in old age. At the same time, because fertility limitation is perceived as temporary, it is not seen as if it dangerously compromises parents' old-age security – at least no more so than does the increasingly common and lamented disregard for filial obligations by modern youth.

The importance attached to children's education demonstrates that fertility limitation is not seen merely as a temporary adjustment of quantity of children in response to the economic crunch. Concerns about the physical and social quality of children – according to the standards of quality imposed by capitalist urban society – are inseparable from those about quantity, although individual preferences may not be articulated in terms of quantity–quality tradeoffs. These concerns about children's quality are further catalyzed by the rapidly increasing and ubiquitously visible socioeconomic differentiation. The appearance of relatively prosperous families, however few they still are in the generally impoverished Maputo suburbs, increases the social pressure on others to try to achieve or at least approach the same level of material comfort and, as part of it, to provide decent food, clothes, and opportunities for their children. "It's good to stop [having children]," concluded the 30-year-old interviewee quoted above, "to see whether we can satisfy our children's needs so that they don't envy other children."

Although the unpredictability of the economic situation is the most important cause of persistent uncertainty about future fertility, other factors also complicate individual reproductive plans. In the context of rapidly changing nuptiality models, marital status and prospects have a particularly strong effect on reproductive preferences. Thus nuptial procedures and transfers, especially the payment of bridewealth (*lobolo*), often become protracted over months and years, and increasingly childbearing starts before they are finalized. However, not only legitimate marriage but even informal cohabitation may not follow a child's birth. The assessment of the likelihood that a relationship will end in marriage or at least in permanent cohabitation therefore constrains reproductive intentions, especially among women. A 26-year-old mother of one who was still living separately from her

child's father thus summed up her reproductive plans: "I would like to have three more children, but with time, when we are together."

Married women often see fertility as one of the few resources at their disposal to reinforce the marital bond and prevent divorce, and in case of remarriage, to cement a new union. Yet this resource proves increasingly ineffective. Marital instability, not to mention separation or divorce, tends to dampen fertility desires, for in a modern urban setting it shifts the burden of childrearing entirely onto women's shoulders. A woman in a focus group explained the need for fertility limitation arising from her husband's unreliability:

> For example, I myself have six children, but when I see that the father begins to stray around, someone has to work to support the children. Life these days is so difficult... I have to sweat while the father runs away. That's why now it's no good to have many children.

Remarriage, on the contrary, generally signifies that women should adjust their fertility plans upward. The following example of a 28-year-old woman with four children from her first marriage, who had just started her second union, illustrates this point when asked if she wanted more children: "I don't want more ... But he [the new husband] just says: 'At least one child for me.' And I want to give him one child because these are not his." At the same time, however, second or subsequent marital unions often tend to be less stable that the first ones, which may negatively affect women's desired fertility. For example, a mother of six who complained about her second husband's extramarital ties, when asked whether she wanted more children first replied negatively but then qualified her answer: "One day I may have more, when I'm happy."

The issue of marital fidelity gained increased prominence in more recent interviews due to rising concerns about HIV/AIDS. In Mozambique adult seroprevalence today is estimated at 16.2% (Mozambique 2005), and HIV/AIDS is rapidly monopolizing the forefront of the national public health discourse. Yet despite the ubiquitous prevention messages, practical experience with the disease's devastating effects remains minimal and perceptions of individual risks are often accordingly vague (Agadjanian 2002b). In such circumstances, individuals are slow to adjust their fertility preferences and choices to HIV/AIDS-related morbidity and mortality risks (Bauni & Jarabi 2000; Rutenberg et al. 2000). The interviews suggest

that the growing concern about HIV/AIDS may affect reproductive preferences indirectly, primarily through a reassessment by marital partners (and especially by women) of their mutual trust and commitments to marriage. Thus the fear of contracting HIV may discourage people from seeking a relationship with someone who is believed (or rumored) to have engaged in risky sexual exploits. This fear may also lead to the dissolution of an already established marital relationship (or to an indefinite postponement of its complete formalization) if the partners see in each other's real or imaginary extramarital sexual ties a potential source of HIV infection. However, direct indications of the connection between HIV/AIDS and reproductive intentions are rare in our data, mainly because HIV/AIDS still remains a rather abstract, even if widespread, menace.

Women's reproductive experiences further heighten the uncertainty about future childbearing. Difficult pregnancies and births may alter women's initial aspirations. A 40-year-old mother of two explained her position: ''Before I always wanted to have six children. That was because we also were six siblings. But I have problems during pregnancy, even during childbirth, you know. And it's not easy. So I just have these two.'' What is important here is that pregnancy and childbirth difficulties have become acceptable arguments against further childbearing. Women who have doubts about their fecundity find questions on future reproduction particularly difficult to answer. For example, a 29-year-old mother of one 10-year-old daughter, who wanted to have more children, when asked how many more children she would like to have could only answer: ''I don't know because I have problems conceiving.''

The survey-based fertility literature commonly defines two mutually exclusive motivations for reproductive control: spacing births and stopping (limiting) procreation. Our data suggest that the dilemma of spacing versus stopping, often taken for granted in demographic research, is not a choice that most individuals face in real life. Because of persistent uncertainties about the household's material conditions and about the durability of the marital bond, both objectives of fertility regulation can coexist as part of the same reproductive strategy. Thus stated intentions to let the last child grow and his mother ''rest'' always imply fertility *limitation* as a possible – and even desirable – outcome. The following answers by a 31-year-old mother of seven exemplify the uncertainty of reproductive intentions: ''[Question] Do you want to have more children? [Answer] Eh, no. More children are necessary but... ah, we are going to rest a little. [Question] So, you

want to rest or stop altogether? [Answer] I can't say that I will stop, because while I am resting, [a child] can appear."

These complex and seemingly contradictory reproductive intentions, where stopping and spacing preferences are indistinguishable, should be better defined as *waiting*. Women and men want to wait and see how their material conditions and marital relations will evolve, whether their children will survive, and even whether their relatives, friends, or neighbors will have another child. Regardless of its actual outcome (which in the conditions of relatively little and often improper contraceptive use is likely to be a pregnancy and birth), the waiting period is subjectively meant for both spacing and stopping.

The ambiguity inherent in waiting tends to diminish as the number of children and age rise. Thus a stated intention to have no more children means different things at different parities. For women with many offspring, who are also generally older, it means a stronger inclination to cease childbearing because the existing children are "sufficient." In contrast, women with fewer children, sometimes as few as two, want to "stop" because "life is difficult," money and jobs are hard to come by, or their partners are unreliable. Such women's stated desires to stop are therefore temporary and conditional on their economic and social circumstances.

Most study participants could express their fertility preferences in numeric terms, which in itself is a sign of the growing acceptance of fertility control (van de Walle 1992). Yet these numeric preferences were rarely seen as concrete and fixed targets and were often qualified in the course of the interview. The typical ideal number of children, as well as the desired number of children for younger low-parity women was four, which was exactly the total fertility rate for Maputo estimated from the 1997 Mozambique DHS. For most study participants, however, this number itself was less important than the sex composition. People generally wanted to have a balanced number of sons and daughters, as it is typical in sub-Saharan Africa (Arnold 1992). Those who wanted to have four children overwhelmingly preferred two "couples." At the same time, people realize that achieving this ideal balance is not easy and compromises and upward adjustments of desired fertility are almost inevitable. Such upward adjustments, however, are not automatic and are pushed against the antinatalist pressure of material "conditions." For instance, a 30-year-old mother of four first said that she did not want to have any more children because of the "situation which is no good," but later on in the interview admitted that she would like to have another son for she had only one. The following

considerations of a 40-year-old man with four children, three daughters and one son, provide another example of the conflict between hardship-driven antinatalism and preferences for children's sex:

[Question] Would you like to have another child?
[Answer] Yes, I would like one more boy.
[Question] So, maybe you'll try to have another boy?
[Answer] I don't know because the cost of living is pressing me so much. Maybe I won't go that far [to have another child]...
[Question] And how long would you like to wait?
[Answer] I would like to wait at least a year.

As is common in studies conducted in sub-Saharan Africa, some women and men in our study could not put a number on their reproductive aspirations, some were not sure whether they wanted to have more children or not, and yet others stated that it depended on god's will. Yet our interviews also showed that such answers did not result simply from indifference toward their reproductive future or the subjective impossibility of controlling fertility, but rather were signs of uncertainties generated by a combination of different and at times conflicting forces that I discussed above. The following statement by a female focus group participant offers an interesting example of this complexity:

[Question] How many children would you like to have in your family?
[Answer] I can't choose this, sister, because few children are not enough either, that's why many children are needed. But the problem is that we have nothing to give them, therefore it is what God gives a person, she has to be patient and bear with it.

Here, a clash between a preference for large family and the perception of economic hardships results in an unlikely compromise of acquiescing in god's will – something that the fertility literature would typically label as a "traditional" attitude.

Of course, many women who expressed no concrete reproductive preferences did so because they did not see that as a matter subject to their individual decision. For men such considerations were less common because the dominant gender ideology positions them as the household's primary breadwinners and decision makers. Notably, however, men's and women's attitudes regarding ideal family size and desirability of fertility regulation and limitation did not differ much. Although male and female study participants stated similar support

for the idea of smaller families, their argumentation differed somewhat. Men tended to focus mainly on economic hardships, high costs of living, and lack of jobs. Although for women material considerations were no less important, they also emphasized the debilitating effects of repeat pregnancies and childbirths on their health and on the health of their children. This is not to say that men were unaware of women's reproductive tribulations: in fact, men tended to think that women are willing to regulate childbearing mainly because they get tired of its physical burden. This burden, however, does not enter the scope of most men's own deliberations, and if it does, it usually happens at high parities, when many women develop childbearing-induced ailments and when both partners strongly favor putting a definitive end to procreation.

Male and female study participants alike rarely reported disagreement or conflict with their spouses over reproductive goals. Yet sometimes this ostensible spousal harmony camouflaged conflicts in spouses' reproductive aspirations. The following statements by a 37-year-old mother of seven children whose husband, according to her, wanted a total of ten children, provide an illustration:

[Question] Have you and your husband had any disagreement on this matter [of how many children to have]?
[Answer] No, we never argue over that.
[Question] Do you agree with everything your husband says?
[Answer] I don't accept everything because I see that we are going through difficult times, and that's when we argue, for I see that it would be difficult for us if we had many children because of [the costs of] their education, clothing, and food....

Such direct confrontations between spouses, however, seem rather atypical, not because spouses tend to have similar tastes and preferences, but because of the nature of their communication. A growing number of studies have used DHS and other similar survey data on spouses' stated fertility preferences and attitudes toward contraception, and conversations on family planning to explain gender relations, contraceptive uptake, and ultimately fertility outcomes (Bawah 2002; Kimuna & Adamchak 2001; Feyisetan 2000; Blank et al. 1996; Meekers & Oladosu 1996; Bankole 1995; Dodoo & Seal 1994; Ezeh 1993). However, given the inherent limitations of the data, the survey-based studies cannot capture adequately and fully the permeating influence of gender ideology and related social norms on spousal relations and interactions. Whenever qualitative inquiry is woven into the

analysis (e.g., Wolff et al. 2000; Pictet & Ouedraogo 1999; Ezeh 1993; Renne 1993), the centrality of this influence becomes apparent. Our study is no exception.

Constrained by the dominant gender ideology that imposes and enforces social distances, both vertical and horizontal, between spouses, husband-wife communication on reproductive matter is usually brief and not contentious. The theme of daily struggle to provide for children's needs rarely extends into the issues of fertility control. These issues become more common – but, at the same time, even less conflictive – in spouses' conversations as the number of children increases to a point that is perceived as sufficient by both of them. Disagreements, if they arise, do not seem antagonistic; they are situational and circumstantial, balancing the traditional sociocultural imperatives, the extended kin's expectations, and the perception of economic hardships and of health implications of childbearing. Moreover, these disagreements are not so much about the number of children per se – which, as both spouses realize, is difficult to control – but more about authority and decision making within the household. Husbands' positions in such collisions tend to be particularly ambivalent: on the one hand, they are aware of the economic and health costs that childbearing entails, on the other, they may perceive their wives' dissension as an attempt to acquire greater autonomy. Here is how a 33-year-old mother of five saw this issue:

> I talk to my husband to see how many children he wants. To know if he still wants to have children. If I see that it is difficult for us because of the [low] wages, lack of clothes and education for children, I tell him that it [the number of children] is enough for me. Then he says he wants more. As men are the ones who rule, he avoids talking to you saying that it is because you don't like to have children.

Interestingly, later on in the interview this woman denied having any disagreement with her husband on reproductive matters.

When focus group participants were asked who – husband or wife – usually prevails when the two cannot agree on future reproductive plans, in general, female participants tended to favor women whereas male participants were inclined to see men as likely ''winners.'' However, women's and men's ''victories'' were rationalized in different dimensions: women were said to prevail because they are the ones who suffer, whereas men's position would get the upper hand because

they are the ones who are supposed to make decisions. Given of the different types of arguments and because actual discussions of reproductive matters are quite rare, a paradoxical situation when both sides could ''win'' was also seen as a possible outcome.

The sporadic and superficial nature of spousal communication on reproductive matters and the gendered perception of its content and outcomes contribute to gendered stereotypization of reproductive preferences. Remarkably, both men and women in our study tended to see the opposite sex as more pronatalist (cf. Wolff et al. 2000). This assessment does not just indicate that the study participants did not know their partners' ''real'' preferences. It reflects continuing attempts by each gender to restate and redress gender boundaries in a changing social and ideological environment

Contraceptive use

Western (modern) contraceptives in Maputo – primarily the pill, the IUD, and injectables (mainly *Depo-Provera*) – are offered by a fairly large network of government-run family planning clinics free of charge to any woman upon her request. (Contraceptives are also available from private pharmacies for a price, but few peri-urban families are willing or able to pay for them.) This system is not flawless: it has been characterized by periodic shortages of contraceptives (even though not frequent in recent years), a limited choice of pill brands and an unpredictable continuity of supply of specific brands, and some restrictions that guide the provision of contraceptives (e.g., younger lower-parity women are usually denied *Depo-Provera* on the grounds that it may cause prolonged sterility). The government-backed vigorous promotion of condoms for HIV/AIDS prevention has increased the popularity of this method, although condom use for contraceptive purposes is by far more common among young unmarried people, and even among them is hampered by rumors of unreliability and harmful side effects.

These limitations notwithstanding, contraceptives are widely and easily available and basic knowledge of family planning methods can be acquired through numerous formal channels. Since the overwhelming majority of city women pass through a formal health care institution before, at, or after childbirth, they are directly exposed to contraceptive messages at least on several occasions, usually in the form of a brief talk or lecture by a nurse during prenatal and postnatal visits to the hospital,

or when leaving the maternity ward after a delivery. Besides, family planning is frequently talked about in the mass media, and usually in a positive way.

The interviews and focus group discussions demonstrated how well-informed city residents are about contraceptives' availability and usage; both women and men spoke generally in support of family planning. Although men were less knowledgeable about nuances of contraception than women, in their majority, they were rather well acquainted with different methods and could opine about their advantages and disadvantages. Despite widespread basic knowledge of contraceptives, however, our data show that the degree of practical exposure to contraceptive use varies according to study participants' sociocultural characteristics. Differences between study participants with more education, whose social and informational world is structured largely on the use of Portuguese, and those less educated, who live in a predominantly Tsonga-speaking milieu, were especially salient: the former generally demonstrated a clearer knowledge of contraception, had greater and more diverse experience with contraceptive methods, and expressed more resolute and concrete intentions to practice contraception in the future than did the latter. These differences appeared particularly strong among women.

The official contraceptive message emphasizes the benefits of contraception for healthy birth intervals: all women are encouraged to start using it two months after childbirth and continue to do so at least until the children are weaned (usually about two years). Echoing this official stance, our study participants generally preferred to word the purpose of contraception in terms of spacing births as well. But as in the case of reproductive desires discussed above, the subjective differentiation of the purpose of contraceptive use was of little importance, and a stated intention to use contraception for spacing was easily reconciled with a strengthening preference for smaller families.

Uncertainties surrounding reproductive desires facilitate the bridging of the two seemingly distinct contraceptive strategies. First, a commonly mentioned qualification that contraceptives should be used to postpone future births "until the situation gets better" already implies that such "waiting" may last indefinitely if "the situation" never improves. Second, in a society where pronatalist inertia is still very powerful, people are generally reluctant to admit that they would like to suppress their reproductive ability permanently or even for long periods. Third, even if a woman thinks that the number of children that she presently has is sufficient, she realizes that the future course

of her marital life may force her to continue reproduction. And finally, people understand that even if contraception is not explicitly used to end reproduction after the acceptable number and sex composition of children are achieved, it will eventually contribute to limiting fertility.

It is important to note that even those women and men who were definitive in their desires to cease reproduction would consider only nonterminal methods. Resistance to sterilization is common throughout sub-Saharan Africa (Dwyer 1990; Bertrand et al. 1989; Chibalonza et al. 1989) and has cultural and practical basis. In a culture that still places a social and emotional premium on reproductive capacity (as different from reproductive outcomes), terminating it before it withers naturally is not easy to accept. The tubal ligation procedure is not widely available (and vasectomy is all but unheard of), and the bureaucratic red tape associated with it may serve as an additional deterrent. Often because of their previous encounters with the alienating formal health sector, many women are frightened by the prospect of yet another one, especially if it involves surgery. Other practical reasons for avoiding sterilization should not be discounted either. Thus even high-parity women who do not want to have more children may not want to "turn the womb around" because if their current marriages dissolve, their fecundity will become a major factor in the formation of new unions. Interestingly, even some men acknowledge this reality. When asked why his wife, who already had many children and wanted no more, refused to get sterilized, he replied: "It's the problem of the situation. One day I may not be here. And then she would like to go on with her life, and if she does it [tubal ligation], she won't be able to, you understand."

As for the nonterminal contraceptive methods, their undesirable side effects were one of the central themes in most interviews and focus group discussions with women and men alike. Real or imaginary, these side effects are clearly a major consideration in contraceptive decisions. Notably, the (in)effectiveness of contraception was rarely seen as an equally critical issue. In a society where fertility regulation and contraception is not ingrained to the point when a contraceptive failure is viewed as a major misfortune, contraception remains experimental, and such facts as bleeding, headaches, and even weight gain or loss associated with contraceptive use may constitute bigger concerns than an unplanned pregnancy.

Largely due to concerns over side effects, misgivings and uncertainties about contraceptives abound and contraceptive use is often experimental

and easily discontinued. The side effects of western methods – experienced or anticipated – may also encourage some women and couples to try the generally less effective natural or folk methods (Agadjanian 1998b). Qualitative interviews, with their effective probing techniques, suggest that many of these contraceptive experiments, especially those involving natural and folk methods, may go unnoticed in surveys because individuals simply may not consider occasional or short-lasting tries in the past as worth reporting as contraceptive use.

It is also typical that women understate their past and current use of contraception if they do it without their partners' explicit approval. Studies in other parts of sub-Saharan Africa have suggested that such secret use is widespread (Castle et al. 1999; Biddlecom & Fapohunda 1998; Renne 1993). Our data revealed that secret use is common in Maputo as well and tends to be underreported unless specifically probed for. However, the interviews and discussions also showed that women sometimes use contraception secretly not because they *know* that their partners are against it, but because they are *unsure* whether they would approve of it or not. The already mentioned distance and lack of communication between spouses is a common reason why this happens. Interestingly, secret use does not necessarily arise from disagreements over reproductive goals between spouses. We encountered cases when the husband and the wife ostensibly had the same reproductive preferences but the wife nevertheless chose not to tell her husband about her using a contraceptive method. Such paradoxes should be explained from the standpoint of culturally bound gender differences in spousal attitudes toward family planning.

The dominant gender ideology figured in study participants' reasoning about how the decision to use contraception should be made. Both men and women reckoned that the partner's approval is necessary for a woman to use contraception and most thought that if the husband opposes it, the wife should give up the idea. However, both women and (somewhat more reluctantly) men admitted that some women, especially those with many children and/or those whose unions falter, would still use contraceptives secretly. Here, we see again a paradoxical coexistence of the adherence to a traditionally prescribed norm of gender subordination with a tolerance of breaking this norm. Although women and men may agree on the benefits of fertility control and even on the general usefulness of contraception to implement such control, when it comes to practice, contraceptive use is often seen through the prism of gender roles in household decision making.

Thus men, while supporting the idea of family planning, often complained that the current system allows women to practice it without the approval or even knowledge of their partners, thereby jeopardizing the peace and integrity of the household. A participant in a male focus group expressed this concern in the following description of the familial battleground:

> I am not dismissing [fertility regulation] itself, but I reject the expression "family planning." Because, in reality, those who have to do family planning are the husband and the wife. But what happens is that there is a lot of confidence on the part of women. Women nowadays are very capable of playing this type of games. They are well prepared to defend themselves... They counterattack...There are men who suffer. Those songs about men going to witchdoctors [to try to have children] or whatever, sound like a fable, but the big secret is with the women. They know what to do to prevent [pregnancy] but tell the husbands that they are not preventing, just can't conceive.... Women have this big secret and always come prepared. For me, family planning doesn't exist. Maybe individual planning, yes, for me it's individual planning.

Men, therefore, often want to see family planning as planning *by* the family, in which they would retain the decisive voice, rather than planning *of* the family. This attitude is produced by men's concerns that their role as primary decision makers in the household is undermined by their growing inability to provide for their families and by the rising autonomy of women in urban society. As men see their control over women's lives and bodies erode, they construe the loss of such control as women's attempt to monopolize family reproduction.

Gender differences are strongly manifested in the perceptions of contraceptives' side effects. As I mentioned earlier, negative side effects of contraceptive methods represent a much greater concern than their effectiveness. However, women and men in our study tended to find different problems with contraceptives. Women were typically concerned with such real or perceived health side effects as headache, hypertension, hemorrhage, infections, or weight gain or loss. Although men knew about these problems from their partners, they seemed more worried about how contraception might affect their enjoyment of sex and how women's sexuality might be influenced by contraceptive use. Thus our male study participants frequently claimed that contraception

renders women sexually frigid. Curiously, men often attributed this concern to women themselves, recounting stories of women desperately trying to regain their sexual desires allegedly lost after injections of *Depo-Provera*. We never heard about this type of problem from female study participants.

It does not mean, however, that women see no connection between contraception and sex. Yet, constrained by the dominant gender ideology that represses female sexuality, women are more likely to focus on the implications of this connection for the strength of their marital union. Thus female study participants often noted that by allowing them to engage in sex shortly after childbirth, family planning helps strengthen their conjugal ties. "If family planning is not practiced what happens?" asked a female focus group participant and then answered her own question, "there is a squabble in the house, because the woman says 'Look, I can't have sex because I am breastfeeding.' So, the man gets angry and goes out. He finds other women, and that causes troubles at home. Now, when you do [family] planning, you avoid that the man goes out and also avoid conceiving early." Notably, for men the effect of contraception on marital relationships was often the opposite: contraception-induced frigidity of women, as some of them commented, forces men to look for outside sex.

At the same time, men are intolerant of the prospect of women's infidelity. Men's worries that contraception would facilitate women's extramarital sex are often reported as grounds for disapproval of family planning (Bawah et al. 1999; Mwageni et al. 1998; National Research Council 1993; McGinn et al. 1989). Male study participants also expressed such worries, even if often disguised by statements of general support for family planning. Rising fears of HIV/AIDS and the energetic promotion of condoms in recent years have added new gender tensions because for many men and women alike the acceptance of condom use is tantamount to legitimating extramarital ties. Here again the gender asymmetry is potent: while female study participants sounded generally more tolerant of their partners' infidelity and in some cases even admitted to having encouraged their partners to use condoms with other women to avoid infection, for most men the very idea of their partners having outside sex, with or without condoms, was inconceivable.

Navigating the uncertainties through informal social interaction

The importance and mechanisms of gendered social interaction on reproductive matters in the Maputo context have been discussed in

detail elsewhere (Agadjanian 2001, 2002b). Here I will only emphasize the differences in how reproductive intentions and contraceptive use enter and travel in the realm of such interaction.

As our interviews and focus groups suggest, reproductive intentions rarely become a direct focus of interpersonal communication outside the spousal unit. These issues are touched upon only tangentially, as an almost accidental byproduct of fairly common conversations on material difficulties of everyday life. Moreover, most exchanges on reproductive attitudes and aspirations occur indirectly, often through nonverbal (visual) interaction. I already mentioned the importance of observing more affluent families with fewer children. Yet social influence is common among families of similar socioeconomic status too – relatives, friends, neighbors, coworkers, coreligionists, and so on. While verbal exchanges within socially homophilous peer networks are frequent, visual observations can be powerful enough to make any direct conversations unnecessary. For example, if a woman's youngest child can already speak but she does not show signs of pregnancy, people automatically assume that she is "resting." Although such superficial and momentary nonverbal encounters often lack accuracy, in a society where the perception of a heavy burden of childbearing is universally shared, they help reinforce antinatalist inclinations.

Unlike reproductive intentions, for the adoption and legitimation of contraceptive practices, verbal communication plays a crucial role. Despite its wide availability, contraception is still seen as a new practice with many unknowns, and its compatibility with traditional norms and forms of fertility regulation is often questioned (Watkins 2000; Rutenberg & Watkins 1997). Besides, contraception is often evaluated in terms of its social meaning and implications, and there is no public consensus on these matters. Like any verbal interaction, communication about family planning is delimited by gender, age, social, and cultural boundaries (Agadjanian 2001). Understandably, such communication is more common among women, who learn a lot from each other's experience, as the following quote illustrates:

> We learn many things, especially about methods, because if I talk with a friend, she can tell me: "I've used pills, and they've worked for me." So, because of this conversation I too will go to the hospital and ask for pills. If they work for me, then I'll be using that method. But sometimes it may not work out well for me ... So, I'll prefer the [intrauterine] device. When I put the device in, I, the one with the device, and my friend who's taking

pills, will exchange our experiences. She'll ask me: "So, how is your device?" And I'll tell her whether it worked well for me or not. So goes our conversation.

Discussion and conclusion

This study suggests that even in an urban society that appears ripe for fertility decline, reproductive changes are accompanied by considerable ambiguities and ambivalence. These ambiguities and ambivalence are rooted in uncertainties about individual and family economic prospects and about the increasingly contested social norms and cultural values underpinning reproductive behavior. Economic woes become a handy and effective "excuse" to adopt and legitimize antinatalist reproductive aspirations without a complete psychological overhaul of traditional attitudes toward reproduction and the value of children. Material deprivation – relative or absolute – offers women and men a culturally acceptable justification for waiting until better times, even though no one knows when such better times will arrive and how exactly they will be better when (or if) they do.

In this social and psychological environment, the complexity of the meanings of reproductive intentions extends far beyond the options offered by the questionnaires of most surveys. As this study shows, what the literature often classifies into a simple trichotomy of "want now – want later – don't want" is in real life an intricate process shaped and channeled by individuals' (couples') assessments of their economic, social, and cultural constraints. This assessment is made by applying differing and sometimes incompatible yardsticks of past, current, and future income opportunities; traditional pronatalist and novel antinatalist values; perceptions of marital stability; and individual reproductive experiences, tastes and aspirations. Consequently, the resulting preferences are tentative and easily changeable, especially at lower parities.

Use of contraception, clouded by similar uncertainties, remains experimental and easily reversible. Despite the official emphasis on using contraceptives for achieving healthy intervals between births, the distinction between their use for spacing and for stopping is subjectively immaterial and is seldom clearly articulated. Moreover, avoiding the side effects of contraceptives often becomes a more important issue in contraceptive use and choice than realizing reproductive preferences.

Although contraception is linked – conceptually and practically – to reproductive aspirations, it is not a simple reflection of them. Thus,

unlike the growing proclivity for fertility limitation that cuts across different social and cultural layers of society, contraceptive use is predicated on sociocultural differences in the perceptions of its benefits and risks. Men, and especially women, who are more involved in the Portuguese-driven cultural and informational milieu appear better attuned to contraceptive technology than those who are less so.

The meanings attached to reproduction and contraception vary by gender. The common assumption that men are more pronatalist than women is not borne out well in this study. However, even if men indeed tend to show a stronger pronatalist penchant, they do so not necessarily because they want more children but rather because they use pronatalist rhetoric as a tactic and a means of asserting their control over women, especially when their economic preeminence in the household is challenged.

Whereas in the articulation of reproductive intentions gender differences tend to be relatively subtle, contraceptive use often becomes an openly gender-contested terrain. Here men's preoccupation with retaining their exclusive decision-making privileges is manifested in their frequent opposition to their partners' use of contraception, which often directly contradicts their approval of family planning in principle (Bawah et al. 1999; Watkins et al. 1997; Green et al. 1995). Marital partners' differences in views of family planning and its health and social implications, resulting from culturally constrained distances and miscommunication between partners, may further promote negative gender stereotypes, reinforce the potential conflict over the adoption of contraception, and therefore discourage contraceptive use or precipitate its discontinuation.

Informal social interaction functions as a major catalyst and vehicle of reproductive changes. Both reproductive aspirations and contraceptive decisions are socially produced, but the mechanisms of this social production differ. Whereas direct social learning plays a relatively minor role in the formation of reproductive goals, intensive communication through social networks is of particular importance in the process of adopting and legitimizing contraceptive use. While informal social interaction generally works to minimize ambiguities and ambivalence by building a shared meaning, legitimacy, and practical knowledge of novel reproductive aspirations and contraceptive techniques, it may also be counterproductive as its gendered nature may help reify gender stereotypes and antagonisms (Agadjanian 2002a).

The foregoing analysis warns against simplistic assessments of fertility preferences and contraceptive use as well as against straightforward

attempts to link these two components of reproduction. Although many aspects of this study's setting may be unique, the puzzling mismatches of reproductive intentions and contraceptive behavior – the proliferation of contraception without explicit intentions to limit fertility (Castle 2003; Bledsoe et al. 1994) or conversely, a fertility decline in the absence of rising contraceptive prevalence (Pritchett 1994) – can occur elsewhere largely as a result of the discussed differences in their social meanings, mechanisms, and determinants. These semantic and behavioral incongruencies are likely to diminish as the fertility decline matures; at the same time, they may prove more resilient than a mechanistic view of the fertility transition would imply, especially as the HIV/AIDS crisis complicates reproductive intentions and contraceptive choices (Moyo & Mbizvo 2004; de Bruyn 2003; Feldman & Maposhere 2003; Hunter et al. 2003).

Analyses based on qualitative data like the one presented here shed important light on the intricacies and contradictions of reproductive preferences and contraceptive behavior that are often hidden behind such widely used notions as ''unmet need for family planning,'' ''contraceptive KAP-gap,'' ''spacing'' versus ''limiting'' births, or ''spousal communication'' on reproductive matters. Yet qualitative studies do not just provide anecdotal quotes to supplement quantitative findings – they tell a real-life story of hope, doubt, trial, frustration, and perseverance. They also help embed reproduction and contraception within a bigger picture of profound and multifaceted social transformations in sub-Saharan Africa. As the subcontinent becomes the new family planning frontier (Caldwell & Caldwell 2002), it is imperative that family planning policies – devised with an ultimate goal of improving people's well-being rather than simply facilitating the fertility decline – take this embeddedness into full account.

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