Project Title: 'Here we are': a demographic life-history of co-wives, social standing and child survival

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Location: Naaga village, Kassena-Nankana District, Navrongo Health Research Centre, Upper East Region, Ghana

Methodology:

Anthropological methods were based on the phenomenological approach of residing in a polygamous household in Naaga village in order to observe the daily sharing and cooperation amongst household members. Life-narratives were conducted for thirty women aged nineteen and above, with a focus on the changing contexts of their relationships over time, reproductive behavior and child health and survival. A district-wide comparative analysis of child survival between women who are currently living in a polygamous union and those in monogamous unions is conducted using a sample (n=1,200) from the Navrongo Demographic Surveillance System (NDSS) to corroborate anthropological findings.

Literature Review: Does polygamy make people sick?

The primary goal of this paper is to investigate the contextual, individual and situational aspects of polygamous marriage and how it might be related to epistemologies of illness and public discourses about the health of the family in northern Ghana. Currently, there still is a growing debate about whether or not polygamy in essence makes people sick. Many social scientists studying health outcomes in sub-Saharan Africa have hypothesized that polygamous co-wives have a greater risk of contracting HIV/AIDS, the children of polygamous unions are more malnourished and exhibit stunted growth, and they have a greater risk of infant and child mortality (see for some examples Slonim-Nevo and Al-Krenawi 2006, Hinks 2008, Oppong 1998, Caldwell, Caldwell and Orubuloye 1992). Rushing (1995) and Kalipeni (1997) are examples of two authors who have made direct claims that polygamy is the largest contributing factor to what has been called 'HIV proliferation' in sub-Saharan Africa (as cited in Oppong, 1998). Various other research, however, has found that most of the differential health outcomes that are found in polygamous households are due to other factors such as mother's education, religious practices, age disparities between male and female spouses and other socio-economic indicators that are common to polygamous unions and not primarily

due to marital composition itself (Hogan 1999, Gibson and Mace 2007, Peterson 1999).

First, however, it is important to discuss (1) how polygamy has been studied in anthropological and other social science literature, (2) the prevalence of polygamy in Ghana, (3) how social change in Ghana and the need for public official discourses to modernize the image of the African family has promoted a transformation in how marriage has been discussed in shifting terminologies of 'polygamy', 'poly partner sexual activity' and 'serial monogamy' and (4) finally how polygamy has been incorporated into current theoretical models of the health of the African family and epistemologies of illness.

Polygynous marriages in West Africa have historically been studied in terms of the underlying biological or evolutionary causes of why a man would want to have more than one wife or why a woman 'would want to marry and already married man?' (Gibson and Mace 2006). The evolutionary or biological anthropological evidence for problematising the existence of polygynous marriages is mostly based on the modes of production, the division of gender roles in agricultural labor, pastoralism, and other settlement patterns (Boserup 1970; Goody 1976; Hartung, 1982; Luttberg et al 2000; and Borgerhoff Mulder 1990). The explanatory models that seek to explain the pattern of polygynous marriages in West Africa have primarily been discussed in terms of male control over female modes of production, labor and sharing of resources. Current research has continued with this approach and has been employed to further examine the 'failures and successes' of marriage based on the evaluation of the number of surviving offspring (Betzing, 1986; Borgerhoff Mulder, 1987; Sellen, 1999). Other explanatory research has discussed polygamy in terms of religious traditional practices, and denominational affiliation in terms of 'traditional', Muslim and Christian practices and belief systems that promote one form of marriage over the other (Gyimah et al, 2008; Adongo et al, 1998, Takyi and Addai, 2002). A few studies have measured the 'success and failures' of polygamous families based on the emotional experiences of partners and children in psycho-social analysis of 'well-functioning families', measurements of female autonomy or the 'life satisfaction' of women in polygamous relationships (Slonim-Nevo and Al-Krenawi, 2006; Hogan, Berhanu and Haeilemariam, 1999; Hinks and Davies, 2008). In rural Ethiopia one study measures the independence of women by the household's living arrangements and if each wife has a separate living space 'with her own hearth and managing her household budget independently' (Gibson and Mace 2007). Whereas Hogan et al (1999) measure female autonomy solely on individual participation in household decision-making.

Some authors, such as J. Oppong (1998), make an explicit distinction between 'polypartner sexual activity' throughout the world and 'polygamy' in Africa. Dan Smith (2007) and other authors have reported on the need of African men to 'modernize' sexual behavior in terms of having extramarital affairs within the confines of a 'modern' marriage, versus 'traditional' practices of 'official' or 'formal' polygamy that codifies and recognizes that having multiple female partners is 'written into the male DNA' (also see J. Oppong 1998). According to the 1993 Ghana Demographic Health Survey 28% of married women reported that their husbands had 'other' wives, with the highest occurrence (44%) of polygynous unions present in the Northern region of Ghana (J. Oppong 1998).

In his article, 'A Vulnerability Interpretation of the Geography of HIV/AIDS in Ghana, 1986-1995', Joseph Oppong discusses the *Vulnerability Theory* used in epidemiology that claims that 'adverse life circumstances such as hunger and disease do not affect social groups uniformly' (1998:p. 438). According to Parker (1996) various social and economic factors place some individuals and social groups at an increased level of vulnerability to disease. It could be interpreted that since polygynous unions have been incorporated repeatedly into several explanatory models of health vulnerabilities that polypartner marital status has been epistemologically linked with illness and the overall health of the family. However, despite being tested in various models several authors have found no significant link between polygamy and HIV (Oppong 1998) or child nutritional status (Hogan et al 1999) and that these health factors may be more associated with levels of cooperation among members of the household and the level of a woman's participation in household decision making.

According to the analysis employed by these authors, health is directly evaluated and attenuated through a husband's ability to enter into multiple marriages concurrently. In order to manage the social perception of her husband's and family's overall social status and well-being a 'healthy' wife would have the added incentive to actively engage and encourage her spouse to 'add one more to the household' (Gibson and Mace 2007). Further studies have highlighted the important resources and assistance provided by co-operating co-wives, in effect, suggesting that women are 'choosing' co-wives for their family as much as their husbands (Irons, 1983; Chisholm and Burbank, 1991).

Preliminary Findings:

Analysis of anthropological and demographic data suggests that living in a polygamous household had a protective effect for child survival in the past (women currently over the age of fifty), but was highly dependent on the mother's social standing within the household. This

paper concludes that social standing for women is greatly associated with the sharing of household resources. Equitable sharing of resources (such as shared cooking pots) proves to be a predetermining factor for providing group support for health seeking behavior among co-wives. Uncooperative living arrangements that exhibited exclusionary practices in sharing access to food had a direct correlation with child mortality and union dissolution for polygamous wives with 'lower social standing'. However, this protective effect of polygamy has greatly diminished over time for women of reproductive age. Findings from this paper suggest that the ongoing debate of polygamous marriages, sharing of household resources and health outcomes should be evaluated within the framework of a comparative historical approach. This paper offers a theoretical model for understanding social standing based on ethnographic fieldwork that proves useful for future demographic research on marriage, household economics, social change, health equity and child survival.