

Men's Involvement in Maternal Healthcare in Accra, Ghana.

From Household to Delivery Room

Gloria Abena Ampim



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Department of Health Promotion and Development

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List of Abbreviations

FGD	Focus Group Discussion
GDP	Gross Domestic Product
GHS	Ghana Health Service
GSS	Ghana Statistical Service
ICPD	International Conference on Population and Development
JHS	Junior High School
MDG	Millennium Development Goals
MOH	Ministry of Health, Ghana
NDPC	National Development Planning Commission, Ghana
NGO	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
SHS	Senior High School
UN	United Nations
UNICEF	United Nations International Children's Fund
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization
USAID	United States Agency for International Development

Abstract

Mid-way through working towards the Millennium Development Goal (MDG) five, which is concerned with improving maternal health, the international health community now realises that the goal is impossible to achieve without involving men as “partners, fathers, husbands, brothers, policy makers and community and religious leaders” (UNFPA, 2007, para.3). Subsequently, there has been a call to educate men on the dynamics of women’s health, especially during pregnancy, childbirth and the postpartum period so that they will give the necessary support. In Ghana, some district health directorates provide incentives to men who accompany their partners to the antenatal clinic by rewarding them financially (Kofoya-Tetteh, 27th Jan. 2012 p.20). Some NGOs and health facilities also organize pregnancy schools for couples to prepare them for the challenges of pregnancy, childbirth and parenting. Despite the growing interest in involving men, few studies have been conducted to explore what and how men support their partners during pregnancy and childbirth, and the factors which shape their support in specific contexts. This thesis is based on a qualitative study conducted with mothers, fathers and healthcare providers in Accra, Ghana to explore the factors that shape men’s participation in maternal healthcare. The thesis draws on Connell’s (1987; 1995) concepts of masculinities and femininities to explore how gender ideals, household and kin relations and healthcare practices shape men’s contribution to maternal healthcare. The study highlights the alteration of dominant gender roles during pregnancy, the reasons which account for this change and social perceptions of the change. It also illustrates the significance of men’s participation in antenatal, delivery and postnatal services and explores why most men are unable to participate. Moreover, the study demonstrates how two healthcare programmes; pregnancy school and the arrangement of serving women who attend clinics with their partners’ first, could shape men’s participation in maternal healthcare as well as alter and reproduce hegemonic masculine ideals.

Keywords: men, maternal healthcare, antenatal, postnatal, pregnancy school, masculinities, femininities, equality.

CHAPTER 1: INTRODUCTION

1.0 Introduction

Until recently, pregnancy and childbirth have generally been viewed as the domain of women, with men relegated to the periphery (Plantin, Olukoya & Ny, 2011). In Ghana, evidence shows that women stayed with their mothers and matrikin during pregnancy, childbirth and the postpartum period, therefore, the matrikin provided antenatal, delivery and postnatal care (Badasu 2004; Jansen, 2006). Men's role was limited to providing money for medical bills and other material needs and naming the baby (Badasu, 2004; Jansen, 2006). Some of these practices still occur in smaller communities (Jansen, 2006). However, in urban areas, immigration and urbanization has fragmented kin ties, and the nuclear family structure has become more common (Badasu, 2004; 2012; Kwansa, 2012). Consequently, kin support for maternal healthcare and other domestic services is becoming uncommon (Kwansa, 2012). In this regard, paternal support in maternal healthcare is becoming more relevant in other ways than simply the provision of financial and material resources.

Mid-way through working towards the Millennium Development Goal (MDG) five, which is concerned with improving maternal health, the international health community now realises that the goal is impossible to achieve without involving men as “partners, fathers, husbands, brothers, policy makers and community and religious leaders” (UNFPA, 2007, para.3). The UNFPA has also indicated that in promoting gender equality, especially in sexual and reproductive health, it is inappropriate to exclude men because men usually have strong reproductive decision-making power in relation to the number of children and the use and choice of contraceptives (UNFPA, 2011, para.1; Ministry of Health, Ghana (MOH), 2009 p.16). Subsequently, there has been a call to involve men in reproductive and maternal healthcare. This call is to educate men on the dynamics of women's health, especially during pregnancy, childbirth and the postpartum period so that they will give the necessary support.

In Ghana, some district health directorates motivate men who accompany their partners to the antenatal clinic by rewarding them financially (Kofoya-Tetteh, 27th Jan.

2012 p.20). Some NGOs and health facilities also organize pregnancy schools for couples to prepare them for the challenges of pregnancy, childbirth and parenting. Despite the growing interest in involving men, few studies have been conducted to explore what and how men support their partners during pregnancy and childbirth, and the factors which shape their support. Some studies conducted in Ghana have focused on gender relations in reproductive decisions and paternal support in childcare, saying very little about paternal support during pregnancy, childbirth and the postpartum period (Adomako-Ampofo, 2001; DeRose, Dodoo & Patil, 2002; Takyi & Dodoo, 2005; Kwansa, 2012). Other studies conducted in some parts of Africa are usually based on quantitative or mixed research methods and not theoretically grounded (Odimegwu et al., 2005; Falnes et al., 2011).

In this thesis, I explore some factors that shape men's participation in maternal healthcare in Accra using in-depth interviews, focus group discussions, participant and non-participant observation. The findings of the study are discussed with Connell's (1987; 1995) conceptual framework of masculinities and femininities.

1.1 Definition of key terms

Maternal health: According to WHO, maternal health refers to “the health of women during pregnancy, childbirth and the postpartum period” (the period just after delivery)¹. *Men* in maternal health broadly refer to men as “partners, fathers, husbands, brothers, policy makers, and community and religious leaders” (UNFPA, 2007, para.3). But this study focuses on men as partners, husbands and fathers. Thus, *men's involvement in maternal healthcare* refers to the social role, support and contribution of men as partners, husbands and fathers towards women during pregnancy, childbirth and the postpartum period.

Gender equality has been defined by Oxfam as giving “women and men the same entitlements to all aspects of human development including economic, social, cultural, civil and political rights; the same level of respect; the same opportunity to make choices; and the same level of power to shape the outcomes of these choices

¹ http://www.who.int/topics/maternal_health/en/

(2003, p.1). What equality means and issues such as equality of what and equality of who has remained debatable (Sen, 1980; Annfelt, 2009). In relation to parenting rights and responsibilities, for instance, Annfelt has illustrated how equality has changed overtime from being “equality-fairness-women” to “equality-fairness-men” in Norway (2009, p.130). Whereas women were seen as underprivileged in the 1970s, men are now seen as the underprivileged in rights and responsibilities towards their children (Annfelt, 2009). With regards to reproductive rights and responsibilities, the International Conference on Population and Development (ICPD) 1994 has emphasized equality as a harmonious partnership between men and women (UN, 1995, p.27). Harmonious partnership, the ICPD 1994 has explained as the sharing of household, childcare and sexual rights and responsibilities between couples. The ICPD 1994 has indicated that harmonious partnership would promote equality between men and women in both private and public spheres (UN, 1995, p.27). Since this study focuses on men in maternal healthcare, the notions of equality and partnership are adopted from the ICPD 1994, to refer to the sharing of roles among couples in the household and responsibilities related to pregnancy and childbirth. Thus, equality and partnership will be used interchangeably.

1.2 Objectives and research questions

The study has two basic objectives. The first is to explore men’s support for their partners during pregnancy, childbirth and the postpartum period, and also to discuss some of the factors that shape their participation. Secondly, the study explores the extent to which men’s participation in maternal healthcare can be seen to shape dominant gender ideas and ideals about reproductive roles. Three major questions are used to guide these objectives:

- In what ways do gender ideals shape men’s decisions and contribution in relation to maternal healthcare?
- In what ways do household arrangements, women’s employment and kin relations shape men’s contribution to maternal healthcare?

- In what ways do healthcare practices accommodate for or hinder men's contribution to maternal healthcare?

1.3 Organization of the study

The study is organized into nine chapters. The first chapter gives an introduction, definition of key terms and the objectives of the study. Chapter two outlines the study context. Chapter three discusses pertinent literature relevant for the study. The fourth chapter focuses on the conceptual framework used to guide the interpretation of the data. Chapter five discusses the methodological underpinnings of the study. Chapters six, seven and eight discuss the empirical data. Chapter six discusses household relations in Accra and its impact on men's participation. Chapter seven focuses on men's presence and their significance at antenatal, delivery and postnatal clinics. Chapter eight examines two healthcare programmes ongoing at the Ghana Police Hospital, Accra and its impact on men's participation in maternal healthcare. Chapter nine is the concluding chapter which highlights the summary and major arguments of the study.

CHAPTER 2: BACKGROUND TO THE STUDY

2.0 Introduction

This chapter outlines the context of the study. It focuses on global health discourses on men in maternal healthcare; the national profile of Ghana in general and in relation to maternal healthcare agendas; and social issues related to pregnancy and childbirth such as kinship, marriage, fatherhood and motherhood. The chapter ends by introducing the research area, Accra and the Ghana Police Hospital.

2.1 Global agenda for men in maternal healthcare

By the early 1990s, gender relations had emerged in the centre of maternal healthcare activities. As part of its actions, the ICPD 1994 admonishes governments to undertake activities which would increase women's access to economic resources, thereby, reduce their domestic responsibilities and improve their decision-making capacity in all spheres of life, especially in relation to reproductive health (UN, 1995, p. 22). In this regard, countries were expected to develop family health programmes which would enhance communication between couples and emphasize male responsibilities in performing household duties (UN, 1995, p.24). The ICPD also indicated that men's involvement in reproductive health, including maternal and child health and family planning, should be promoted by governments and included in educational curriculum beginning from the earliest ages (UN, 1995, p.28).

Henceforth, involving men has been drawn to the centre of maternal and reproductive health agendas by the international health community. In 2004, the UNFPA, citing examples from Guatemala and Egypt, indicated that men's social support to their partners during pregnancy and childbirth could produce positive health outcomes for maternal and child health such as healthy live births among others (UNFPA, 2004, Men and maternal health, para.1; See also Alio et al., 2011; Plantin, Olukoya & Ny, 2011). However, men's support is often curtailed by hospital and employment policies as well as lack of communication with their partners (UNFPA, 2004). Thus, the UNFPA recommended projects such as the Pati Sampack in India which gives pregnancy and childbirth information to husbands (UNFPA, 2004,

para.3). In 2007, the UNFPA chose *Men as Partners in Maternal Health* as the theme of the World Population Day because “it is now clear that the target of reducing maternal deaths with 75% by 2015 will not be met without the concerted efforts of all involved”, especially men (UNFPA, 2007, para.3). Subsequently, the UNFPA has been advocating for and supporting programmes involving men in maternal healthcare in countries such as Zimbabwe, Nigeria, Philippines, Vietnam, Thailand and Brazil (UNFPA, 2007). These programmes emphasize partnership between men and women during pregnancy and childbirth.

2.2.0 National Context

Ghana has an estimated population of 24,223,431 (Ghana Statistical Service (GSS), 2011). The economy of the country depends mainly on agriculture which forms about 55.8% of adult labour (National Development Planning Commission (NDPC), 2010 p.3). The economy also depends on petty traders, artisans, technicians and businessmen and women, mining and a new oil sector which started in 2009 (NDPC, 2010, p.3). The country practices a democracy and has ten administrative regions. The adult literacy rate in 2010 was estimated to 67% and life expectancy in the same year was rated 64 years.² Ghana is ranked as 135th position in human development index.³ The gender equality index in the country is 0.598 and ranked 122nd out of 146 countries.⁴ In 2011, Ghana ranked the 70th position out of 135 countries with a score of 0.6811 in the global gender gap.⁵

The average current fertility rate is estimated to 4.0 (GSS, 2009, p. 3). In the urban areas, fertility is rated 3.1 while in the rural areas, fertility is rated 4.9 (GSS, 2009, p. 4). In Accra, fertility is rated 3.1 (GSS, 2009, p.4). This is reflected in my study as most participants had an average of two to three children. In the 1990s, surveys indicated that decision-making patterns with regards to the expected number

² http://www.unicef.org/infobycountry/ghana_statistics.html

³ <http://genderindex.org/country/ghana>

⁴ <http://genderindex.org/country/ghana>

⁵ <http://genderindex.org/country/ghana>

of children in the family reflected male rather than female preferences, and influenced women to have more children than they wanted (Baden, Green, Otoo-Oyortey & Peasgood, 1994, p.47). However, the 2008 demographic survey indicates that men and women are increasingly discussing and deciding together the number of children in the family (GSS, 2009).

Maternal morbidity and mortality is still high in Ghana despite various attempts such as intensifying family planning and safe abortion campaigns, to reduce it. Recent available data has revealed that in 2010, the maternal mortality rate for Ghana was 350 per 100,000 live births.⁶ A retrospective study conducted in the Tamale Teaching hospital has also shown that the hospital recorded 280 maternal deaths between January 2006 and December 2010 (Gumanga & Kyei- Aboagye, 2011, p.105). Statistics from the Komfo Anokye Hospital, Kumasi also estimated that maternal mortality rate between January 2008 to June 2010 is 1, 004 per 100, 000 live births (Lee, 2012, p.87).

In 2009, the Ghana Ministry of Health (MOH) drew a gender policy to ensure that health campaigns and delivery services are reaching men and women equally. As part of this policy, women are to be empowered to enable them make decisions concerning their reproductive health (MOH, 2009, p.25). In addition, it is stated that men should be encouraged to use reproductive health services and support their partners in using contraceptives (MOH, 2009, p.32). In 2012, some district health directorates decided to motivate men who accompany their partners to the antenatal clinic by rewarding them financially (Kofoya-Tetteh, 27th Jan. 2012, p.20). Some public health facilities and NGOs like USAID also organize and support a programme, popularly called pregnancy schools to educate couples on women's health issues. A preliminary report of USAID indicates that an ongoing pregnancy school, in the Ellebelle District, located in the Western Region of Ghana, had increased mothers' and fathers' attendance to the antenatal clinic. This has helped reduce maternal deaths from 12 in 2009 to 5 in 2010 and 3 in 2011 (USAID, 2012, p.68). Despite the growing

⁶ <http://apps.who.int/gho/data/node.main.214?lang=en>.

interest and programmes targeted at involving men, men are mostly not granted paternity leave in Ghana.

2.2.1 Kinship

There are two main lineage systems in Ghana; patrilineal and matrilineal. In the patrilineal system, husbands and fathers are inherited by their children while in the matrilineal system fathers and husbands are inherited by their sisters' children (Salm & Falola, 2002). In both systems, couples receive support from kin for childcare and domestic duties.

Among the Ewes, a patrilineal group, mothers usually have their first born with their natal families (Badasu, 2004). The mothers and matrikin provide antenatal, delivery and postnatal services and support the woman with household chores during pregnancy and after childbirth (Badasu, 2004; 2012). Usually, the mother is confined indoors for some weeks when she does not perform any household duty apart from breastfeeding the baby, though this differ in the various communities. The naming ceremony usually takes place on the eighth day where the father names the baby. Though childcare is a core responsibility of a mother, it is also supported by the entire family and lineage as well as the community (Badasu, 2004; 2012). Similar patterns also occur among matrilineal groups. However, in the matrilineal system, children are born into a mother's kin group and as such maternal uncles and relatives make major financial and social decisions concerning the child.

Nevertheless, it has been indicated that Christianity and colonial institutions disrupted matrilineal ties because of their emphasis on fathers' moral and economic responsibilities towards their children (Clark, 1999, p.72). Laws about family and inheritance in Ghana today also place more emphasis on parents and children than extended family members (Clark, 1999). Moreover, urbanization and immigration has fragmented the lineage system and limited kin support for childcare (Badasu, 2004; 2012). Thus, the nuclear family structure is becoming more common, especially in urban settings like Accra. In this regard, though informants and participants in this study belonged to different ethnic and kin groups, this is not used as a category for analysis.

2.2.2 Marriage, motherhood and fatherhood

In Ghana, boys are generally socialized at an early age to take up leadership and decision-making roles while girls are socialized to take up domestic and reproductive roles (Adomako-Ampofo, 2001). Marriage is a significant marker of adulthood in Ghana. It usually involves the payment of bride price (wealth) from the husband and his kin to the wife and her kin. This practice is performed among both patrilineal and matrilineal groups (Dodoo, 1998). Some scholars have indicated that the payment of bride wealth bestows authority and decision-making power to the husband and his kin (Dodoo, 1998; Boateng, Adomako-Ampofo, Flanagan, Galloway & Yakah, 2006). In this sense marriage in Ghana forms a site for endorsing predominant gender notions; that the man is the head and the woman is the subordinate.

In marriage, men and women are expected to procreate and continue the family lineage. Childbirth is very important to both men and women in constructing masculinity and femininity. A real man should be able to impregnate a woman and a real woman should be able to conceive (Tettey, 2002; Badasu, 2004; 2012; Jansen, 2006; Sossou, 2006). Barrenness is shameful and usually blamed on women (Badasu, 2004; 2012).

Men and their families often have little roles to play during pregnancy, childbirth and the postpartum period. After childbirth the man names the child and is also responsible for his/her upkeep, providing food, shelter, clothing and paying medical bills (Boni, 2002; Badasu, 2004; Jansen, 2006). The mother is responsible for childcare and performing household chores (Clark, 1999; Boni, 2002; Badasu, 2004; Jansen, 2006; Sossou, 2006). Boys are trained by their fathers and paternal kin in the patrilineal system and by the maternal uncle in the matrilineal system. Girls are trained by their mothers and matrikin.

In the 1970s, economic situations in Ghana affected men's work and financial contribution to the household (Clark, 1999). Women started providing for the household and other dependants (Clark, 1999). Women's work in the informal sector and formal sector is now widespread in Ghana. Moreover, immigration and urbanization represent an increased need for women to work outside the home

(Badasu, 2012; Kwansa, 2012; Oppong, 2012). This was reflected among participants in my study as most women work outside the home.

2.2.4 Research area: Accra and the Ghana Police Hospital

Accra is the capital of Ghana and the capital of the Greater Accra Region. In 2010, the entire region recorded a population of 3,909,764 (GSS, 2011, p.10). Women in the region have an average of 2.5 children, compared to other regions like Northern Region which records an average of 6.8 children per woman (GSS, 2009 p.3). In Accra, men and women work in the formal sector as teachers, accountants, secretary among other occupations and the informal sector as petty traders, hairdressers, seamstresses, carpenters among other occupations (See also Overa, 2007). Accra has diverse ethnicities from all parts of Ghana and marks the centre of social transition in the country. Accra also has a growing number of pregnancy schools/classes organized for couples by public and private organizations, including the Ghana Police Hospital, where data was collected for this study. The Ghana Police Hospital was built in 1976 and located at Osu, a suburb of Accra.⁷ It is a public facility opened to all Ghanaians and has clients who use the Ghana National Health Insurance Scheme (NHIS) as well as clients who do not. This hospital was selected because it is a public facility and has one of the oldest pregnancy schools in the country, since 2000. Selecting this facility enables the study to explore one of the numerous pregnancy schools in Ghana. And because the school has lasted for at least a decade, it is easier for participants to indicate how it has influenced their attitudes and practices towards maternal healthcare. In this light, this study focuses on residents in Accra who use the Ghana Police Hospital for maternal healthcare services.

⁷ http://www.ghanapolice.info/police_hospital.htm

CHAPTER 3: MASCULINITIES, POWER RELATIONS AND MEN’S PARTICIPATION IN REPRODUCTIVE HEALTH: A LITERATURE REVIEW

3.0 Introduction

This chapter reviews studies conducted in Ghana, Africa and other parts of the world on issues related to men’s involvement in maternal healthcare. In this regard, the review is organized to cover three relevant subject matters of the study; the construction of masculinities and femininities, power relations in reproductive health and men’s participation in maternal healthcare.

3.1 Construction of masculinities and femininities in relation to fatherhood and motherhood

Lindsay & Miescher have made a distinction between manhood and masculinities emphasizing that while manhood refers to an adult male body, masculinities are characteristics which are achieved by men and sometimes women (2003, p.5). In this light, they also refer to “feminine masculinity” which is achieved by women through the performance of tasks preserved for men (Lindsay & Miescher 2003, p.5). In the literature, some ways of constructing masculinities in the African context include marriage, bravery, leadership and the “big man status”, which is related to wealth and large households (Barker & Ricardo, 2005; Lindsay & Miescher, 2003; Miescher, 2005).

For example, in Zambia, Dover (2005) has related that expectations of manliness revolve around the term *murume akasimba*. A *murume akasimba* is a man who exhibits self-reliance, hard work, success, provides for family and kin, and who is brave, stoic and generous (2005, p. 178). Women could also be referred to as *akasimba* when they show such characteristics (Dover 2005, p. 178; See also Achebe, 2003; McKittrick, 2003). Femininity is constructed in terms of women’s productive and reproductive activities in the home (Dover, 2006, pp.175-176). The study illustrates how women and young people perform the task of *tsika*, which embody

showing respect for men and emphasizes male superiority over female (Dover, 2006, p. 179).

A study among adolescents in Ghana has also revealed that boys see masculinity as an achievement which must be earned through the performance of certain tasks (Boateng et al., 2006). Consequently, an important marker of adult masculinity is the avoidance of tasks such as cooking, sweeping and laundry associated with femininity (Boateng et al., 2006). Boys or men could perform such activities when they are single or in marriages as a form of assistance, but not as a responsibility. The study also indicated that some Ghanaian adolescents say the man is the head of the household and therefore makes the major decisions concerning childbirth, use of contraceptives, among others (Boateng et al., 2006). Such expectations of manliness in Zambia and Ghana form part of the hegemony of masculinities and femininities in the African context (Connell, 1995; Dover, 2005).

Richter and Morrell (2006), in an overview of fatherhood in Africa, have indicated that a man is expected to take up the responsibilities of fatherhood by impregnating a woman and accepting and performing the role of a father (Richter & Morrell, 2006 p. 16). Fertility is very important in constructing masculinity and femininity in Africa (Inhorn, 2005). In Egypt, as indicated by Inhorn (2005), infertile men are not regarded as real men. Thus, infertile men are reluctant to discuss the issue with their partners or seek medical care (Inhorn, 2005). Subsequently, women are often blamed even though they may not be the cause of infertility in the relationship (Inhorn, 2005). Childbirth among women also marks the transition to womanhood in Ghana and other parts of Africa (Tettey 2002; Jansen, 2006; Aseffa, 2011). In this regard, women who have children are regarded as more feminine than women who have no children (Jansen, 2006).

The second aspect of fatherhood mentioned by Richter and Morrell (2006) is mostly associated with the tasks men perform in marriages as providers for their families and kin. In this regard, a good father is the one who provides and the bad father is the one who is unable to perform such responsibilities (Richter & Morrell, 2006). Literature in Ghana has also shown that men achieve masculinity by protecting

and providing for their families (Miescher, 2003 p. 97; Miescher, 2005). Among the Kwawu an Akan group, men are expected to look after the health of their wives and children, provide food and shelter and rear their children and find them suitable marriage partners (Miescher, 2005; See also Jansen, 2006).

Among the Asante, another Akan group, a husband is obligated to provide money for food for his household (Boni, 2002). This could be arranged on a daily or monthly basis or in the form of giving his wife an asset which she could manage and use its profit to provide for the household (Boni, 2002, p. 65). Women are expected to be submissive, support their husbands on their farm, heat water for a bath for their husbands, prepare meals and perform other domestic activities such as childcare (Boni, 2002, p. 68). However, there are women who accumulate wealth independently, mostly referred to as *female men* (Boni, 2002, p.68). Women with such status, some participants in Boni's (2002) study claimed, pose a threat to men who see them as not submissive and shunning their domestic duties (p.68; See also Allman and Tashjian, 2000; Allman, 2001). Thus, participants in the study claimed that a man has to provide for his household in order to ensure his wife's submissiveness (Boni, 2002, p. 68). However, Boni's (2002) findings showed that most men are unable to meet the standards of providing for the household, making the expectation an ideal rather than practice.

Some scholars have argued that this delineation of roles are associated more with the influence of colonialism and Western ideas about gender roles than traditional African social ideals (Oyewumi, 1997; Silberschmidt, 2006). Oyewumi (1997) has indicated that traditional African societies did not have gender specific roles. Even so, recent evidence has shown that the delineation of roles among men and women in marriages has become more of an ideal than practice. For example, Clark acknowledges that among the Asante, a husband's role is paying school fees, medical bills, rent, clothes and other expenses while he receives domestic services such as cooking in return (1999, p.73; See also Jansen, 2006). By the late 1970s, economic crisis had started changing the standards of husband's contribution and wives had started supplementing what they received from their husbands (Clark, 1999). Thus,

some women worked to provide for household resources in exchange for duties such as cooking (Clark, 1999). Tolhurst & Nyongator's (2006) study among a Ewe group in Ghana has also indicated that women are becoming providers of the household without a corresponding shift in men's responsibilities (See also Oppong, 2012).

Evidence from Zambia has also revealed that women are taking up the responsibility of providing for their families but still maintain the "customary ideas around womanhood" (Dover, 2006, p. 177). However, as men are unable to live up to social expectations, the society sees women's autonomy as threatening the moral order (Dover, 2006). This issue is illustrated even more strongly in Silberschmidt's (2006) study in East Africa. The study pointed that men are feeling disempowered due to women's engagement in the labour market (Silberschmidt, 2006). Consequently, some men have resorted to other behaviours such as drunkenness, domestic violence against their partners and keeping multiple sexual partners to assert their masculinity (Silberschmidt, 2006). In relation to women's provision for the household, this thesis intends to explore how men are equally performing household tasks such as cooking, washing and taking care of children.

Kwansa (2012) has demonstrated that working fathers in Accra, Ghana are actively involved in childcare and share domestic duties with their partners. He explained this is due to the changing working condition of couples, the dwindling of kin relations in childcare and the high cost of buying household services from the market (Kwansa, 2012). These changes posit some important issues which are examined in this thesis. For instance, how do such changes draw men into the field of pregnancy and childbirth and how are ideas about masculinities and femininities engaged during pregnancy, childbirth and the postpartum period.

3.2 Gender and power relations in reproduction

The ICPD 1994 emphasized that it is important to enhance communication between couples on sexual and reproductive health matters since men play a key role in decision-making which relates to such issues (UN, 1995, p. 27). The conference also encouraged activities that will promote equal participation of men and women in household and family responsibilities (UN, 1995). Hence, a global focus on gender

and reproductive health has encouraged couple friendly health programmes to promote partnership between couples in making reproductive decisions (Mullany, Hindin & Becker, 2005). While such programmes are promoting partnership, there are other programmes on women's empowerment which emphasizes women's autonomy to make decisions concerning their reproductive health (Ministry of Health, Ghana (MOH), 2009). Some studies have shown that partnership and joint decision-making in maternal healthcare is preferable to men and women than absolute female autonomy (Carter, 2002a, p.276; Mullany et al., 2005; Tolhurst & Nyongator, 2006). In Guatemala as explained by Carter (2002a), women and men see making decisions together about maternal healthcare as a way of expressing love to each other. A study in Nepal has also indicated that joint decision-making in the household was most desirable among participants in order to share the blame in case of negative effects (Mullany et al., 2005, p.2003). Nevertheless, Mullany et al. (2005) noted that such joint decision-making patterns are likely to be male dominated.

Some studies conducted in Ghana have also highlighted that joint decision-making is perceived as better because it is a way to evade blame even though men usually dominate in many cases because it is their responsibility to provide (Tolhurst & Nyongator, 2006). According to Tolhurst & Nyongator (2006), because fathers are responsible for paying for healthcare, it is expected that they should be consulted about where and when to seek healthcare. They could refuse if they are not consulted and women could decide to take their children provided they have the resources. However, it was better to consult the father to evade blame (Tolhurst & Nyongator, 2006; Tolhurst et al., 2008). Even though this study concerned child healthcare, similar patterns of decision-making could be related to health seeking behaviour for women themselves, especially in relation to contraception.

Male dominance in decision-making has been identified as one of the causes for low use of contraceptives in Ghana (Do & Kurimoto, 2012). Do & Kurimoto's analysis, based on demographic health surveys, reveal that unlike Namibia, Uganda and Zambia which are examined alongside Ghana in the study, economic situation of women did not affect the use or non-use of contraceptives. However, husband's

disapproval was mentioned by Ghanaian women as the reason for not using contraceptives (Do & Kurimoto, 2012). Do and Kurimoto (2012) also identified the fear of physical abuse, punishment and insults from extended family members as causes for non-use of contraception among Ghanaian women. However, Do and Kurimoto's analysis does not provide specific examples of how extended family members could prevent women from using contraceptives. Similarly, a quantitative study conducted in Cote d'ivoire has illustrated that extended family members could maltreat women in relation to reproductive health decisions, and influence women's decisions in terms of the number of children and the choice of contraceptives (Gupta, Falb, Kpebu & Annan, 2012, p.1062). Yet, Gupta et al. (2012) do not illustrate specific types of violence perpetuated against women.

Jansen (2006), in a qualitative study conducted in Kwame Danso, a small community in Ghana, has also explained that decision-making during pregnancy resides mainly with older female relatives. This is because of their experience in pregnancy and childbirth, which makes the society regard them as knowledgeable (Jansen, 2006). Older female relatives advise younger women on what to eat, where they should deliver and who should support during delivery among other issues (Jansen, 2006, p.45). In this community as Jansen explained, younger women are not supposed to explicitly say no to older women in terms of lessons about pregnancy (2006, p.44). However, the study does not indicate whether younger women see this as a form of interference or not. In this regard, in addition to exploring the possibility that male partners could prevent women from using contraceptives, this thesis explores how couples perceive extended kin support in maternal healthcare.

In addition to the economic status of women, education has also been identified as insufficient to provide women the autonomy to make reproductive decisions (DeRose, Doodoo and Patil, 2002). DeRose et al. (2002) study conducted among young men and women in educational institutions, revealed that women's educational level does not necessarily produce autonomy in making reproductive decisions. The study indicated that most participants, undergraduates in tertiary institutions, mentioned that they discuss with their partners about the number of

children in the family and the use and choice of contraception (DeRose et al., 2002). However, in terms of having another child, the decision of the pro-natalist partner, which was mostly the husband, dominated (DeRose et al., 2002, pp.62-63).

Takyi and Dodoo (2005) have acknowledged that while the educational level of a woman may not necessarily give her autonomy and greater control over reproduction, lineage sometimes gives a woman the power to translate her reproductive ideas into practice. This is similar to an earlier claim by Adomako-Ampofo (2001). Adomako-Ampofo's qualitative study among matrilineal and patrilineal girls identified that girls in the matrilineal society see the social distribution of domestic and reproductive responsibilities as unfair while those from the patrilineal society do not exhibit such concerns (2001, pp.204-5). However, Adomako-Ampofo's (2001) findings do not show whether and how the ideas expressed by girls from the matrilineal society are practised.

A study conducted in two rural and two urban communities among women in Ghana with different educational, socio-economic and employment backgrounds has also highlighted the role played by cultural ideals in household and reproductive decisions (Sossou, 2006). The study indicated that both urban and rural participants mentioned that male partner performance of household duties and childcare was lacking (Sossou, 2006, Findings, para.5-8). In addition, even though most participants were aware of their reproductive rights, they were unable to exercise these rights due to social expectations of women in marriage (Sossou, 2006, Findings, para.9). Women could decide the number of children they want to have but their partners and families could expect them to have more, especially when it had to do with having a male child (Sossou, 2006, Findings, para.10-11). Some women are therefore coerced to have more children because of the fear that their partners may engage in extramarital affairs. Some women also decide to use contraceptives secretly without their partner's knowledge (Sossou, 2006, Findings, para.12).

Urbanization has also been identified as a factor which affects reproductive decisions (White et. al., 2005; See also Badasu, 2012, Kwansa, 2012; Oppong, 2012). Urbanization implies different household economics which require women and men

working outside the home (White et al., 2005). In addition, contraceptives could be more accessible in urban areas (White et al., 2005). Moreover, lack of kin support for domestic and childcare in the urban areas could influence couples to delay and reduce birth (Badasu, 2004; White et al., 2005). Since my study was conducted in Accra, an urban area, it would be difficult to examine how lineage affects women's autonomy and decision-making in reproductive healthcare. However, factors related to urbanization such as the employment situation of men and women as well as the economic contribution of both men and women to the household and kin relations are explored in relation to making reproductive decisions and men's involvement in maternal healthcare.

3.3 Men in maternal healthcare

Even though studies on male involvement in maternal healthcare are limited in Ghana, the topic has been explored in South America and Asia in ways relevant to this study. Carter (2002a; 2002b) has identified that men in rural Guatemala are not relegated to the periphery of pregnancy and childbirth. Husbands form a source of information about maternal healthcare to women and also participate in delivery when it takes place at home (Carter, 2002b, p. 443). Carter (2002a) also indicated that "machismo" does not appear to be the dominant factor underlining male involvement in maternal healthcare. During pregnancy and childbirth, traditional gender boundaries are altered because men perform roles such as cooking. Moreover, women are able to demand more money from their partners when the partners are aware that it is important for their healthcare. However, sometimes men's employment situation constrained them from attending antenatal clinics. In addition, even though men are able to advice their partners on pregnancy and give them household support, they are unable to stay in the delivery room when it occur at the hospital because it is not allowed. Thus, she concluded that men as well as employers and hospital policies should be considered in the agenda to involve men (Carter 2002a; b). Similar to Carter's study, this thesis explores gender practices during pregnancy and childbirth, the reasons why men are (un)able or (un)willing to participate in antenatal, delivery and postnatal services. It also examines the influence of hospital policies on men and women's lives during pregnancy and childbirth.

In Nepal, Mullany (2006) has identified that low level of knowledge among men, social stigmatization of men who support their partners with household chores, influence of mother-in-laws, hospital policy and work obligations are barriers to husband's participation in maternal healthcare. The evidence from this study has shown that shyness sometimes compelled some women to communicate details of their pregnancy to their mothers-in-law or sisters-in-law instead of their husbands. Some husbands did attend antenatal visits to hear about the details of the pregnancy. Interestingly, husbands' visit to the antenatal clinic seemed to improve the interaction between doctors and women. In relation to men's presence in the delivery room, most women in this study agreed that it should be allowed so that men will witness the pain of women, which again could reduce men's fertility desires (Mullany, 2006). Most of these issues raised in this study from Nepal are explored in Ghana concerning men's involvement.

Studies conducted in some parts of Africa have discussed the challenges of involving men in maternal and child welfare services using quantitative and mixed research methods (Tweheyo, Konde-Lule, Tumwesigye, & Sekandi, 2010; Nkuoh, Meyer, Tih & Nkfusai, 2010; Falnes et al. 2011). In Uganda, men in a peri-urban setting are more likely to attend antenatal clinic than those in a rural setting (Tweheyo et al., 2010). In addition, Tweheyo et al. (2010) noted that knowledge about antenatal services, obtaining information from health workers and proximity to health facilities determines male attendance to antenatal clinic. Thus, they have suggested that governments should empower men with knowledge about antenatal care to increase male attendance and thereby improve maternal health (Tweheyo et al., 2010).

Evidence from Cameroon (Nkuoh, et al., 2010) and Tanzania (Falnes et al., 2011) has indicated that men are reluctant to attend antenatal clinics because they view the clinic as a female arena. In addition, some Tanzanian men see it as offensive to take instructions from women (Falnes et al., 2011). Thus, women are unable to communicate adequately to their partners about the healthcare instructions given at the clinic. As a result, some men lack the knowledge to give the necessary support. Given

that they were conducted in Africa, similar socio-cultural issues discussing to how and why men participate in antenatal and postnatal care are explored in this thesis.

Some examples of how men participate in pregnancy and childbirth have been highlighted in a study conducted in Nigeria among the Yoruba (Odimegwu et al., 2005). Odimegwu et al. (2005) have indicated that some men remind women of clinic days and encourage them to comply with medical prescription. In addition, the study indicated that men are increasingly getting involved in maternal welfare, for instance, by discouraging their pregnant wives from performing tasks such as pounding yam and carrying heavy loads. Some men also encourage their wives to eat fruits and do physical exercises during pregnancy (Odimegwu et al., 2005). Pregnant women could decide where to seek healthcare during emergency. Significantly, the study concluded that gender does not underlie the choice of when and where to seek healthcare, rather, the economic situation does. Even though gender may not underlie the choice of when and where to seek healthcare, gender could underlie the forms of support men give to their partners during pregnancy and this is explored in my study.

3.4 Contribution of my study

Studies conducted in Ghana have focused on men in family planning and men in childcare (Adomako-Ampofo, 2001; Koster, Kemp & Offei, 2001; DeRose, Doodoo and Patil, 2002; and Kwansa, 2012). Oppong (2012) has argued that male support for maternal healthcare in Ghana is low making women to simultaneously perform the task of mothering as well as participating in the labour market (See also Mosse, 1993; Sossou, 2006 and Islam, 2011). Thus she has raised the question “who should be held responsible to support women in these roles?” This thesis looks beyond who should be responsible to support women. Rather, it examines how and what men contribute to maternal healthcare. It examines the social processes which shape men’s participation similar to what has been studied in other contexts in Guatemala, Nepal and Nigeria among others (Carter 2002a; 2002b; Odimegwu et al., 2005; and Mullany, 2006). Some of these processes include the altering of gender roles during pregnancy. Important also are social perceptions about men who perform household duties, reasons why men and women think it is important that men actively participate in

maternal healthcare services, such as antenatal and postnatal clinics, pregnancy schools and delivery sessions. In addition, it explores health policies targeted at involving men and how they impact gender relations and maternal healthcare services.

Thus, this study makes two major contributions to the literature on masculinities and femininities and reproductive health. First it contributes to the available literature on men's involvement in maternal healthcare by studying this phenomenon in a specific social context. It expands the available literature on gender and reproduction in Ghana by including the topic of men's participation in pregnancy and childbirth. Finally, it explores men's involvement not only as relevant in improving maternal health outcomes but also as relevant to the social construction of gender and issues of equality and partnership in the household and society at large.

CHAPTER 4: CONCEPTUAL FRAMEWORK

4.0 Introduction

This chapter explains the conceptual background of the thesis. It starts by explaining Moore's (1994) ideas about how gender identity and practices are constructed. It continues to discuss how Connell's concept of masculinities and femininities could be related to men's participation in maternal healthcare. Finally, the chapter discusses Africanist perspectives on masculinities and the relevance of such arguments to the study.

4.1 Gender identity and practice

According to Connell,

*Gender is the structure of social relations that centres on the reproductive arena, and the set of practices that bring reproductive distinctions between bodies into social processes. To put it informally, gender concerns the way human society deals with human bodies and their continuity, and the many consequences of that 'dealing' in our personal lives and our collective fate*⁸ (2009, p.11).

The construction of gender is multiple and constitutes a process instead of a fixed category (Moore, 1994, p.58). In this regard, different gender discourses are subject to change in time and space, and could co-exist at a given time in a given context (Moore, 1994, p.59). This also means that there are multiple femininities as well as masculinities. Subsequently, some femininities/ masculinities could dominate others and various subordinate forms could emerge in resistance to the dominant ones (Moore, 1994, p.59).

At different times individuals are required to act out their subject positions which will require them to construct themselves according to the social definition of a man or a woman (Moore, 1994, p.56). In choosing to act, individuals are motivated by

⁸ I have chosen this definition of gender because my study centres on men and women's roles and practices around reproduction.

emotional, social and economic benefits “which are the reward of the senior man, the good wife, the powerful mother or the dutiful daughter in many social situations” (Moore, 1994, p.65). While subordinate gender practices which resist dominant models could be individually satisfying, choosing them could be at the “expense of such things as social power, social and even material benefits” (Moore, 1994, p.65). In this sense, the practice of gender could be seen as entangled in a web of individual satisfaction, material reward and social approval. This conception is relevant for explaining why men and women choose different forms of gender practice and identities at different times.

4.2.0 Hegemonic masculinity

Connell’s definition of masculinity is related to his definition of gender, which he relates to structure and social practice (Connell, 1995; 2009). Masculinity is defined as “simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture” (Connell 1995, p.71). Masculinities and femininities are performed based on circumstances that are presented by culture and history (Connell, 1995; Coles, 2009). Thus, what is considered masculine/feminine in a society may not be considered masculine/feminine in another society. Similarly, what is considered masculine in a society at one time may not be considered masculine at another time. Connell (1995) has also noted that different forms of masculinities could emerge. However, there is a dominant form which leads the other forms and this he calls hegemonic masculinity (Connell, 1995).

Hegemonic masculinity as a conceptual framework was developed in the 1980s from Gramsci’s notion of social class formation (Connell, 1987; 1995; Wetherell & Edley, 1999; Coles, 2009). Connell has defined hegemonic masculinity as “the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women” (Connell, 1995, p. 77). Hegemonic masculinity, which is the leading or dominant masculine practice among other masculine practices, is also fluid in space and time (Connell, 1995).

Hegemonic masculinity explains the relationship between men and women as well as the relationship among men. Thus, hegemonic masculinity is enacted in relation to other masculinities and femininities (Connell, 1987; 1995). According to Connell (1995), not all men live up to the dominant expectation of masculinity. In such cases, men who are unable to live up to the dominant practice produce subordinated models which could be aligned with femininity (Connell, 1995, p. 78). At the same time, there are some men who may not practice the dominant ideal but may support and benefit from it and such men are described by Connell as complicit (1995). Finally, some men are marginalized, not due to gender but as a result of age, class, race and ethnic affiliation (Connell, 1995). Connell also suggests the term emphasized femininity as referring to the compliance with the subordination of women and “accommodating the interests and desires of men” (Connell, 1987, p.183). There are two other forms of femininity identified by Connell, that is, resistant or non-compliance, and the other as “complex strategic combinations of compliance, resistance and co-operation” (Connell, 1987, pp.183-184).

This study uses the idea of hegemonic, subordinate and complicit masculinities, as well as emphasized and other femininities. The study does not use the notion of marginalization in terms of class or ethnicity since this it is not applicable in the context under study. Men and women who participated in this study use the same health facility. Even though they have different social backgrounds related to differences in age, ethnic affiliation and employment, the study does not aim to explore discriminations based on their social background.

4.2.1 Hegemonic, subordinate and complicit masculinities and emphasized femininity

Individuals may express different forms of masculinity; dominant, subordinate or complicit at different times and in different contexts (Mumby, 1997; Lusher & Robins, 2009). For example, the notion of fatherhood as a social marker of masculinity in Ghana requires that a man should be able to impregnate a woman, and also protect and provide for his wife and children. In case a man fulfils the first part by impregnating a woman, he has exhibited a dominant masculine ideal. However, if he is

unable to provide for his family then he is expressing a subordinate model. At the same time, if his wife provides for the household, but he still holds up to the image that a man is the provider, then he is complicit. Thus, in a given instance multiple masculine identities could be expressed.

Lusher and Robins (2009) have explained an interaction between the various forms of masculinities. They have indicated that while hegemonic masculinity dominates subordinate forms, it allies with and leads complicit forms (Lusher & Robins, 2009, p.402). There is also a possible interaction between emphasized femininity and hegemonic masculinity. Emphasized femininity, like complicit masculinity, could have a positive relationship with hegemonic masculinity (Lusher & Robins, 2009, p.402). While resistant femininity, like subordinate masculinity, could have a negative relationship with hegemonic masculinity (Lusher & Robins, 2009, p.402).

Demetriou (2001) has criticized Connell concerning the relationship that exists between the different forms of masculinities. Demetriou has indicated that Connell presents a hegemony that is separated from subordinated and marginalised models (Demetriou, 2001, pp.346-347). In contrast, Demetriou has shown that different forms of masculinity “are in constant interaction” (2001, p.346). Consequently, the formation of dominant models could be influenced by subordinate and marginalized models through challenge and resistance (Demetriou, 2001, pp. 346-355). The ability of subordinate and marginalized forms to influence hegemonic ideals has later been added to Connell’s theory (Connell and Messerschmidt (2005). Connell and Messerschmidt (2005, p. 348) have indicated that some subordinate practices of masculinity have the agency of becoming dominant models over time. Thus, hegemonic forms could be challenged and resisted by women as well as men. Subsequently, some of the features of subordinate masculinity and resistant femininity could influence dominant forms to “construct a new hegemony” (Connell, 1995, p. 77; Demetriou 2001; Connell & Messerschmidt, 2005).

The relationship between multiple masculinities and femininities could be useful in exploring changing gender roles in societies, for instance, in relation to

urbanization, economic changes, and the impact of local and foreign culture and institutions. In recent years, more women have been noted as providers for the family in Ghana (Tolhurst & Nyonator, 2006; Opong, 2012). How does this affect the hegemonic ideal that the man is the provider and decision-maker of the family? Are new forms being constructed or are men and women being complicit? These are some of the questions that will be explored by using Connell's concept in the empirical sections of this study. In addition, Moore's (1994) notion of investment in subject positions could be useful in discussing why men and women choose some forms of masculinities and femininities over other forms.

4.2.2 Individual, cultural and structural/institutional reproduction of hegemony

As indicated earlier, Connell's concept of masculinities is intricately linked to his notion of gender. On the formation of gender, Connell has noted that gender is socially embodied so that bodies are both agents and subjects of social practice (2009, p.67). Such social embodiment includes individuals', groups' and institutions' practices (Connell, 2009, p.67). Connell has argued further that bodies encounter gender by engaging in different institutions such as family, school, media and church among others (2009, p.99). Even though these institutions may not rigidly impose on bodies specific practices, they may influence the networks and groups which individuals encounter and in the process, individuals may adopt and reject some practices (Connell, 2009, p.99). In summary,

Seeing gender learning as the creation of gender projects makes it possible to acknowledge both the agency of the learner and the intractability of gender structures. Gender patterns develop in personal life as a series of encounters the learner improvises, copies, creates and thus develops characteristic strategies for handling situations in which gender relations are present – learns how to 'do gender' in particular ways. Over time, especially if the strategies are successful, they crystallize into recognizable patterns of femininity or masculinity (Connell, 2009, p. 101).

Likewise, in the configuration of hegemonic masculinity, Connell has emphasized that hegemony can only be established when there exists cooperation between cultural and institutional practices, either individually or collectively (1995, p.77). Subsequently, the construction and reconstruction of hegemonic masculinities calls for new strategies with which gender is practiced by individuals in the society (Connell & Messerschmidt, 2005, p. 846).

Other theorists on gender practice also share the view that institutions are effective in influencing individuals in social practices (Scheper-Hughes & Lock, 1987; Brittan, 1989, Moore, 1994 and Bourdieu, 2001). Brittan (1989), arguing about how structure influences individuals, has suggested a distinction between masculinity and masculinism. “Masculinity are those aspects of men’s behaviour that fluctuates over time” and “masculinism is the ideology that justifies and naturalizes male domination” (Brittan, 1989, pp.3-4). This could imply that changes in gender practice would be effective when the ideas and structures which justify gender inequality changes (Brittan 1989; Lusher & Robins, 2009).

Bourdieu (2001), in his *Masculine Domination*, has pushed this argument further indicating that men’s domination over women is enacted and reproduced through institutions such as family, church, school and the state. Bourdieu identified the family as the first place where masculine domination is established through “the sexual division of labour and the legitimate representation of that division, guaranteed by law and inscribed in language” (2001, p. 85). The church is “dominated by patriarchal values” which claims that male domination and female subordination is ordained by God (Bourdieu, 2001, p. 85). The school also promotes masculine domination through its syllabuses which convey the idea of male superiority to female (Bourdieu, 2001, p. 86; See also Kambarami, 2006). Finally, he emphasized that the state justifies “private patriarchy” through “public patriarchy” reflected in the institutions responsible for social and domestic affairs (Bourdieu, 2001, p.87). Bourdieu concluded that the only way to alter masculine domination is when political actions challenge the structures through which gender and social practice are configured and reconfigured (2001, p. 117).

These arguments show that hegemonic masculinity could be socially produced and reproduced by institutions and acted by individual bodies. However, hegemonic masculinity is not the most common lived experiences of men and boys; rather, it is the “exemplars of symbols of authority” (Connell & Messerschmidt, 2005, p.846). In this regard, the everyday experiences of men and women engage these enacted exemplars of masculinities to produce subordinate, complicit and marginalized forms of masculinities as well as different forms of femininities (Connell, 1995; Connell & Messerschmidt, 2005).

In relation to this thesis, cultural ideals about gender and institutions (healthcare system) will be examined to explain how they could enact, alter and reproduce masculinities in the household and at health facilities. In addition, the study explores how individuals, women and men, engage masculinities in their everyday lives (Coles, 2009).

4.2.3 Africanist perspectives on masculinities

Post-colonial scholars have cautioned researchers on Africa about the use of western concepts and theories because such theories may not be an effective way of understanding African realities (Oyewumi, 1997; Lindsay & Miescher, 2003; and Miescher, 2005). On gender relations, Oyewumi citing the Yoruba as an example, has articulated that the Yoruba society is genderless and that “maleness or femaleness did not have social antecedents and therefore did not constitute social categories” (1997, p. 13). She continued to indicate that “social hierarchy was determined by social not gender relations” (Oyewumi, 1997, p. 13). Terms such as feminine and masculine were imposed by Western scholars on African societies and therefore “African thought should not be founded on western intellectual traditions” (Oyewumi, 1997, p. 22).

Lindsay and Miescher (2003) have related Oyewumi’s argument to the use of the notion of hegemonic masculinity in African studies. They have argued that in colonial Africa, it was not obvious which masculinities were dominant at a given time; rather multiple dominant forms could exist at the same time (Lindsay & Miescher 2003, p. 6). Thus, using historical and ethnographic examples, they have cautioned researchers on Africa about the use of Connell’s concept (Lindsay & Miescher, 2003;

Miescher, 2005). For instance, Miescher (2003) has shown that colonial ideologies and social opportunities presented during the colonial period resulted in multiple dominant masculine practices which were contested and negotiated by men in Ghana. Similarly, McKittrick (2003) has demonstrated that before colonialism in Namibia, masculinity was mainly defined in terms of fatherhood, as fathers initiated their sons into adulthood by passing unto their sons properties in terms of livestock (McKittrick, 2003, p. 34). However, a new group of elites emerged with the advent of colonialism, reducing young men's dependency on their fathers (McKittrick, 2003, p.34). These new elites were dominant over other men and women. Yet, this new dominant group could not replace or "construct a new hegemony" over the practices surrounding fatherhood. Even though there were tensions between the two, none lived longer than the other, but the two co-existed (McKittrick, 2003, p.34).

Hodgson has also presented the case of the Maasai, where dominant masculinity was mainly defined in terms of pastoralism and undiluted Maasai cultural practices (2003, p. 213). There was a term *Ormeek* which represented subordinate masculinity linked to "modern" Maasai men (Hodgson, 2003, p. 213). This term, according to Hodgson was associated with all non-Maasai Africans, but during colonialism the term also referred to educated and baptized Africans who had been "westernized" (2003, p.219). However, the term changed over time to become less critical because the early converted Christians and educated men had educated their children, making education important in Maasai (2003, p.221). Also, the new political economy gave the *Ormeek* more power and money than the pastoralist (Hodgson, 2003, p.221). Soon, some Maasai men who were attached to pastoralism and Maasai culture were beginning to feel less powerful (Hodgson, 2003, p.222). Thus, the term *Ormeek* no longer carried the weight of the past. Rather Maasai men embraced ways in which they would not lose their cultural practices like seniority or circumcision and simultaneously, participate in modernity (Hodgson, 2003, p.222). Thus, Hodgson concluded that the Maasai encounters with modernity shows that dominant masculinity is always produced through a process of negotiation and mediation (2003, p. 226).

Cornwall (2003) has also illustrated how in Ado Ado, a dominant masculine notion of men as owners, controllers and providers had changed over time to become more associated with the task of providing for the family, a Western ideal (Oyewumi, 1997; Silberschmidt, 2006). Cornwall gathered her data in 1992 and 1994, a period in which structural adjustment programmes had created economic crisis and caused unemployment among men and women (Cornwall, 2003, p.231). Some of her informants were born in the 1920s and 1930s while others were about 30years old. The study showed that the ideal is that a man who is a husband is the controller of the household. However, economic situations drew more women into trading activities which enabled them to perform the role of providing for the family more actively than their husbands. Some men had to perform household chores due to their wives' employment. Women challenged the notion of men being in control since women were performing the role of providers, such that authority and control was measured with provision. In this regard, men who could not provide also could not control or claim authority over women. Consequently, the ideal notion of masculinity, even though still referred to by women and men, are not reflected in the lived experiences in Ado Ado (Cornwall, 2003).

These examples presented above show the multiplicity of masculinities in the African context which are contested, negotiated and changed over time (Lindsay & Miescher, 2003). Lindsay & Miescher (2003) have also indicated that studying masculinities in Africa should give attention to institutions which construct masculinities, during which period, in which context and how it took place (Lindsay & Miescher, 2003, p. 7). They also acknowledged that gender and masculinities are enacted and produced through the interaction of men and women with local and translocal structures (Lindsay & Miescher, 2003, p. 7). This point overlaps with Connell's argument that hegemony cannot be constructed unless there is mutual interaction between culture and institutions, either individually or collectively (Connell, 1995, p.77).

Furthermore, some examples presented above could also show how subordinate masculinities could influence hegemonic models to change over time to

produce new forms (Demetriou, 2001; Connell & Messerschmidt, 2005). In Maasai, it could be explained that a subordinate model influenced a dominant model to “construct a new hegemony” (Connell, 1995, p.77; Demetriou, 2001; Connell & Messerschmidt, 2005). In Ado Ado, it could also be explained that men and women were more complicit since some men couldn’t live up to the dominant model but at least both men and women engaged and sustained it (Connell, 1995). Acknowledging that there could be multiple dominant masculinities in the African contexts, in the following section, I explain why I choose to use hegemonic masculinities in studying men’s participation in maternal healthcare in Ghana.

4.3 Why Hegemonic masculinity

The involvement of men in maternal healthcare relates to notions of masculinities and fatherhood, femininities and motherhood. In this regard, it is relevant to explore how masculinities are produced, altered and reproduced to influence men’s involvement or lack of such. Men’s involvement in maternal healthcare is not only about improving maternal health but also relates to questions of equal participation in the performance of household duties, childcare and sharing the burdens related to reproduction. Men’s involvement also speaks to issues of kinship and relatedness. For example, Middleton (2000) has described how men become mothers in Karembola by performing housework, which is regarded as “women’s work”, during the postpartum period. This process gives fathers the opportunity to claim paternity and show how they give life to their children (Middleton, 2000, p.117). In this study, I explore men’s performance of household tasks in light of kinship and ideals of relatedness and how these ideals also shape dominant masculine ideals.

In this light, Connell’s concept of hegemonic masculinities could be useful to explore gendered power relations between men and women, among men and among women as the empirical section of this study will show (See also Wetherell & Edley, 1999, Demetriou, 2001; Coles, 2009; Lusher & Robins, 2009; and Dolan & Coe, 2011). As suggested by Africanist scholars, critical attention will be paid to the possibility of numerous dominant masculinities in relation to fatherhood, pregnancy and childbirth (Lindsay & Miescher, 2003; Miescher, 2005).

Another important aspect of gender relations emphasized by both Western and Africanist theorists is the importance of context, structure and institutions in constructing masculinities and femininities. In this regard, the healthcare system will be explored to examine its role in shaping social practices among men and women during pregnancy and childbirth. Given these two aspects of masculinities outlined as relevant for this study, the empirical section answers questions such as how gender relations are enacted, altered and reconfigured by individuals, culture and structure, and the impact of these processes on men's participation in maternal healthcare; and what are some of the strategies men and women adopt to resist, challenge and engage dominant gender ideals? Exploring these issues using hegemonic masculinities does not indicate that the study overlooks femininities. However, this conceptual framework enhances an understanding of changing gender relations, the role of institutions in the process of the change, and how individuals engage these changes in their daily lives.

CHAPTER 5: RESEARCH METHODOLOGY

5.0 Introduction

The aim of this study is to examine why, how and what men contribute to maternal healthcare. In this regard, qualitative research methods were preferred in order to understand this social phenomenon from the perspectives of participants and informants (Yin, 2011, p. 136). This chapter explains the methods used in gathering the experience, perceptions and practises of mothers, fathers and other relevant actors in the field. It also describes the study area, how and why informants were selected and the implications of the researcher's decisions and role in the data gathering process.

5.1 Data collection unit

Accra, Ghana's capital, populated with people from different parts of the country and therefore, culturally heterogeneous, was selected as a site for collecting data in order to access people from a variety of backgrounds. In order to access pregnant couples and relevant actors/background informants such as nurse-midwives, and to examine how pregnancy schools were working to involve men, a health facility was selected. This explains why the Police Hospital was selected as an appropriate site.

The Police hospital was established in 1976 and it provides healthcare services for police officers, their dependants and the general public⁹. In other words, the hospital provides services for people from a variety of backgrounds. The hospital is located in Accra, near Danquah Circle. Since 2000, the hospital, with the initiative of one of its staff, a public health nurse, has organized a pregnancy school for pregnant couples on coping with pregnancy and other related issues. This pregnancy school is one of the oldest of such initiatives in Ghana and because of its success other health facilities are taking similar initiatives. In addition, the hospital prioritizes women who attend antenatal or postnatal clinics with their partners by attending to them first before women who are not accompanied by their partners.

⁹ http://www.ghanapolice.info/police_hospital.htm

I gained access to the hospital through contacts from NGOs who are focused on maternal healthcare in Ghana. First, I contacted the USAID person in charge of maternal healthcare in Ghana who introduced me to the John Hopkins Bloomberg School of Public Health, Center for Communication Programs which is running projects on maternal healthcare. The John Hopkins Group then introduced me to another NGO, Focused Region Health Project, which had direct contact with the Police Hospital. This way, I came into contact with the head of the Public Health Unit of the hospital and with his permission, I was able to observe and select all informants and participants for the study. I personally recruited all informants and participants without any interference from the hospital administration. This was important to ensure that proper informed consent and voluntary participation were enforced.

5.2 Selection of informants

All informants were recruited at the police hospital; at the antenatal clinic, postnatal clinic and the pregnancy classes held twice a month on Saturday mornings at the premises of the hospital. However, not all participants in the study participate in the pregnancy classes. Informants and participants were selected because they were mothers, fathers or nurse-midwives. Selection also took place through observations at the health facility. For instance, the first informant was a man who I saw sitting at the antenatal clinic. I approached him, asked him why he was at the clinic, explained the study to him and he agreed to be interviewed. Purposeful sampling was used for the focus group discussion where women were selected based on their employment or educational backgrounds to create a background similarity in each group. This method was also used in order to explore perceptions about the same phenomenon across diverse groups of women (Krueger & Casey, 2009).

Recruiting through a health facility made it easier to locate pregnant and nursing mothers as well as relevant actors in maternal healthcare. It also gave access to the pregnancy school where observations and discussions provided an insight into how the pregnancy school influences men's participation. It also provided an opportunity to observe men and women's attitudes during antenatal and postnatal visits. In addition, the attitude of healthcare providers towards men and women was observed.

5.3.0 Data collection methods

This study engaged multiple methods, by using in-depth interviews, focus group discussions, observation and informal conversation to corroborate each other and triangulate the data (Silverman, 2010). Triangulation has enabled the study to examine the lives of participants and informants from a variety of sources to increase credibility and trustworthiness (Yin, 2011).

5.3.1 In-depth interviews

In-depth interviews are semi structured interviews with open-ended questions (Yin, 2011; Kvale and Brinkman, 2009). Five interviews were conducted with mothers and five with fathers, and one with a grandmother. These mothers and fathers belong to different ethnic groups, educational background and live in different parts of Accra (See appendix 1a). However, the differences in their social status were not large and so this is not an issue followed up in analyzing the data.

The interviews were conducted in Twi and English and lasted approximately 45-60 minutes. Interviews took place at the health facility in a private room provided by the hospital, under trees at the premises of the hospital and also in homes, according to the preferences of informants. An interview guide with open-ended questions about themes relevant to the study was used (See appendix 2b and c). Some of these themes included gender roles and men's participation, household arrangements, as well as the financial, physical and emotional expectations of men during pregnancy and childbirth.

In order to create rapport with the informants, broad questions were asked first (Yin, 2011). Informants usually answered such questions with stories and examples, mostly making references to themselves. Specific follow up questions relevant to the study were asked inspired by their examples. In this regard, most of the interviews followed a conversational mode and generated a social relationship between the informants and me differing from one participant to the other (Yin, 2011). Most participants were relaxed and openly shared their experience, but a few remained closed. For example, the grandmother was reluctant to speak. As a result, the interview with her was short and many issues were left uncovered.

In addition, four in-depth interviews were conducted with relevant actors in the field (See appendix 1c). These background informants were selected because of their direct involvement with mothers and fathers at the health facility and the community. All background informants had tertiary education and work as a nurse-midwife, public health nurse, community nutritionist and a social psychologist. The social psychologist was recruited because she participated in the pregnancy school as a student in 2002 and is currently a facilitator at the school. Interviews with these relevant actors revealed what was happening at the health facility and in their communities and provided specific examples that some mothers and fathers had shared with them.

I tried not to put any normative constraints on my informants while conducting the in-depth interviews in order not to offend participants and at the same time grant them ownership of the process (Yin, 2011). Most often, I introduced myself as a Masters student in Norway without stating that I am studying Gender and Development, thinking that this could influence some of the answers of informants.

5.3.2 Focus group discussion

A focus group discussion “is a carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, “nonthreatening” environment” (Krueger & Casey, 2009, p.2). Focus groups provide an understanding of how people feel or think about an issue. Such groups usually compose between four and twelve participants who share similar characteristics according to the interest of the subject matter under study (Krueger & Casey, 2009). In order to gather the ideas and perceptions of mothers about men’s participation in maternal health, four discussions were conducted. In these groups, pregnant women and nursing mothers between the ages of 20 and 41 were engaged in a discussion with open-ended questions covering different aspects of men’s participation in maternal healthcare in Ghana (See appendix 2e and f). All discussions were conducted in Twi and lasted approximately 60-75 minutes.

The first group was composed of seven pregnant and employed women while the second group was made up of four women, three were employed but one was not (See appendix 1c and d). Women in these two groups had different ethnic affiliations

and different educational background ranging from no education to tertiary education. These two discussions took place in a private room provided by the health facility. Open-ended questions covering broad themes about the roles of a father and mother plus men's role in pregnancy and delivery were asked for women to share their ideas (See appendix 2e). Because the first group was large, a few participants dominated the discussion while others resorted to nodding in support of ideas raised. In the second group, all four participants equally shared their views and ideas.

The third and fourth discussions took a different shape; they took place in a private room at the health facility but instead of open-ended questions, a story was used to start the discussion (See appendix 2f). The story was about a man who performs household chores, but was mocked by certain members in his community and work place. This story was developed from issues raised in the first two discussions as well as discussions that had been ongoing in the media concerning changing gender roles in Ghana. Participants were asked to comment on the story and based on their comments, specific questions relevant to the study were asked.

In the third group, there were eight pregnant and nursing mothers with the same level of education but different employment and ethnic background (See appendix 1e). Though the group was large, all the women actively engaged with each other and expressed their views. Perhaps this was because the discussion began with a story and participants felt they were discussing someone else's life. Though, most participants compared and contrasted the story with their personal experience. The last group was made up of six unemployed nursing mothers with different ethnic and educational background (See appendix 1f). Though the discussion began with a story like the third one, participants did not engage each other in a discussion and instead provided straight forward answers reflecting dominant gender norms. As a result, very little information was collected from this group.

Apart from the fourth group, focus group discussions provided a more natural environment for some participants to speak perhaps due to influences from other participants (Krueger & Casey, 2009). Unlike in-depth interviews which were unidirectional sometimes, participants in the focus groups argued with each other,

disagreed sometimes and agreed other times. Sometimes, in the midst of the argument, some participants sought my opinion. I remained neutral by asking other participants to also share their views before I shared my opinion. By the end of the discussion, participants were content and no longer interested in my opinion.

In addition to the focus group discussions, I led one large discussion with about 20 women and one man at a pregnancy class on a Saturday morning. Though this discussion does not fit into the description of a focus group, it produced ideas and perceptions as well as personal experiences of women during pregnancy and childbirth. Thus, findings from this discussion form part of the analysis.

However, focus groups could not be conducted among men because too few of them showed up at the health facility. This made it difficult to recruit about four or more men at a time to participate in a discussion. In this case, it could seem that the focus groups that were conducted will not provide a full range of opinions across diverse groups (Krueger & Casey, 2009). Nevertheless, the focus groups conducted cover diverse groups of women in terms of employment and educational background.

5.3.3 Observation and informal conversation

Observation, both participant and non-participant, was conducted at different times and places to triangulate the data. Firstly, observation took place at the health facility at antenatal and postnatal clinics. I took notes of how many men attended the clinic with their partners and their body language and attitude at the clinic. For example, some men sat in the car throughout the process and waited until their partner was done. Some just dropped their partners and left and picked them up after they were done at the clinic. Others sat among the women with earphones and listened to music. Yet others carried the baby's bag or older children and conversed with their partners throughout the process. Some men also participated in the antenatal and postnatal discussions by contributing when the nurses asked questions.

Secondly, observation occurred at the homes of informants. In one instance, an in-depth interview was conducted with a mother who happened to be home alone at the time. In the other instances, informal conversations were conducted with couples.

Thirdly, participant observation was conducted at the pregnancy class on two occasions with the help of a male research assistant. I recruited this male assistant because I learnt that men were more comfortable joining the pregnancy class when they saw other men sitting among the women. On the first occasion, I decided to only observe and take notes. But while taking the notes, I realised that the facilitator looked at me uncomfortably. Thus, I stopped taking notes, listened and participated in ongoing activities such as demonstrating how to bath and breastfeed a baby. After the class, an informal conversation was held with a couple. On the second occasion, I led a discussion at the pregnancy school on men's performance of household tasks and support during pregnancy and childbirth, and whether women were satisfied or not. The research assistant took notes during this discussion.

5.3.4 Text

I gained access to two text documents, the manual of the pregnancy school prepared by the facilitators and a report on maternal healthcare activities in other parts of Ghana prepared by USAID. Some vital information from these texts has been added to the background information of the thesis in chapter two.

5.4 Challenges and limitations of the study

Because the data was collected in the city, it was difficult to get immersed into the everyday lives of informants and participants as it unfolded. Thus, possibly, some of the information from interviews may not reflect the real practices of couples. However, the few observations conducted at homes will be used to complement the information gathered in interviews and focus group discussions. It would also have been interesting to hear couples share their ideas and practices together. However, couples were not interviewed, neither together nor separately. On the first day in the field, I recruited a man and his wife; they agreed to be interviewed in the private room provided by the health facility. Yet when the session began, the woman remained silent and made the man the mouthpiece. I encountered a similar situation the next day and therefore decided to stop interviewing couples together. But some informal conversations and observations were conducted with couples, which, even though not sufficient, will be used in the analysis to complement the data.

In-depth interviews were quite difficult to conduct. This was because informants were selected at the health facility after they had spent a lot of time and were in a hurry to leave. Even though I was willing to go to their homes or wherever they wanted to have the interview, most of them preferred some space at the health facility, either under a tree or in a private room. As a result, in the first few interviews, I felt guilty and thought I should let them go quickly. However, after staying in the field for a while and knowing how much some informants had to say, I became relaxed and asked them further questions from their stories and examples. Thus, the data that was collected covered a lot of individual experiences and practices as the study set out to do.

5.5 Ethics and reflexivity

According to Kvale and Brinkman, ethics and moral conduct is central to the craftsmanship of qualitative studies (2009, p.61). Thus, all qualitative researchers ought to take basic ethical principles seriously (Kvale & Brinkman 2009; Silverman, 2010). Informed consent, voluntary participation, confidentiality, critically assessing the researcher's role, and consequences of the research on the researched should be carefully considered (Kvale & Brinkman 2009, p.61). In this study, informed consent, voluntary participation, anonymity and confidentiality were carefully administered before interviews and discussions began. I carefully explained the study and its purpose to informants and participants and emphasized that they could choose not to participate or opt out during the process. Consequently, some people recruited refused to be interviewed or to participate in discussions. All informants and participants were not required to provide their names and all they said has remained confidential. In the cases of informal conversations, informed consent was administered at the end of the discussion and the permission of informants was sought to add what they had said to the data.

Gatekeepers, mainly healthcare providers such as public health nurses and nurse-midwives, were helpful in gaining access to the field. They had control over other informants which in one instance placed me in a more powerful situation vis-a-vis the informants (Lal, 1993, p.193). During the discussion at the pregnancy school,

the public health nurse in charge asked me to prolong the discussion and ensure that women were engaged for three hours. This she explained was because if the time was shorter women will feel their time had been wasted. Because of the access she granted, I agreed to this suggestion but did not prolong the discussion because it would have been unfair to the women.

In collecting the data, I had different identities (Amadiume, 1993). Some participants saw me as an insider because I had similar ethnicity, cultural and local understanding, and speak the local language. In addition, educated participants were more relaxed in expressing themselves than less educated participants. However, most informants and participants kept referring to me as “madam” even though I several times asked them not to.

Nevertheless, I felt like an outsider most of the time; not married and never been pregnant. It was difficult listening to people wishing me a happy marriage at the end of each interview or discussion, especially when some of these informants were younger. One of the informants asked “how old are you, are you married?” After my response he said: “you are the same age with my younger sister and she is married. I pray you find a good man to marry soon so that you will know how beautiful marriage is” (Fieldwork in Accra, 19th July, 2012). Similarly, some women saw me as naive about maternal health issues since I am childless. As a result, they took charge of the process to educate me on how painful pregnancy and childbirth are, and kept saying that it is something every woman should experience. This diverted the conversation sometimes but it still produced relevant information because I asked relevant questions from some of their stories.

5.6 Data handling and analysis

All focus group discussions and in-depth interviews were digitally recorded and anonymised. The analysis took place gradually in five different stages; organization of the data, disassembling the data, reassembling, interpreting and drawing a conclusion (Yin, 2011, p.178). The detailed interviews and discussions have been transcribed in English. The transcripts and other notes from the field was organised in a database and read several times. Overlapping, contradictory and variant

themes were identified. The findings have been conceptually linked to preconceived theories and theories which emerged in the field. Interpretation has been done by constantly making comparisons within a local and wider context. The next three chapters are dedicated to the task of analyzing the findings.

CHAPTER 6: HOUSEHOLD RELATIONS AND ITS IMPACT ON MEN’S ROLE AND CONTRIBUTION TOWARDS MATERNAL HEALTHCARE

6.0 Introduction

“Maternal care, disrupted by too early, rigid and harsh labour demands on the one hand and inadequately supported by kin, partner or community on the other.....The question is ultimately how should reproduction and production be combined over the life cycle and who should be responsible for supporting and helping pregnant and nursing mothers in these simultaneous task?” (Oppong, 2012, pp. 51-52).

This question posed by Oppong (2012) refers to the dwindling of kin and community support as well as low partner support in maternal healthcare. In many cases, women’s participation in the labour market does not reduce their reproductive and domestic responsibilities (Mosse, 1993; Kabeer, 2004; Oppong, Badasu & Wærness, 2012). Instead, women tend to multi task, combining their roles as mothers, wives as well as employees outside the home. At the same time, evidence from Ghana has indicated that kin support for childcare and domestic duties is dwindling because the nuclear family structure is becoming more common (Oppong, Badasu & Wærness, 2012). Moreover, it is quite expensive to purchase domestic services from the market (Oppong, Badasu & Wærness, 2012). Thus, Oppong (2012) has posed the question, who should be responsible for helping women socially and economically to play their roles so they could enjoy some leisure?

Even though Oppong (2012) has indicated that there is low partner support in maternal healthcare, this chapter will explore whether this is changing, and identify the factors underlying the change. The chapter focuses on men as fathers and partners of women, and interrogates what they do to support women in the household during pregnancy and childbirth. The chapter starts by examining how housing situations and women’s participation in the labour market affect gendered division of household labour and men’s involvement in maternal healthcare. It continues to explore the dwindling of kin support in maternal healthcare and how this change shapes men’s

participation. Finally, it discusses the expectations of fatherhood and motherhood as the core definition of men and women's role in the household and contribution towards childbirth.

6.1 Household arrangements in Accra

Household arrangements of residents in Accra who participated in this study can be grouped in three categories. The first is those who dwell in compound houses with shared facilities such as toilets, bathrooms, kitchens and common halls/verandas. The second group is those who live in compound houses but with their private facilities like kitchen, toilet and bathroom. The last group is made up of private gated compounds which could be rented or personally owned. Such housing arrangements are determined by the financial situation of couples, where couples who have more resources are more likely to live in their private apartments. The first and second housing types were the most dominant among participants and informants in this study. Most of the informants and participants live with their partners and children in a nuclear family structure. Extended family members come in when the family is expecting a child or after the family has had a child. Having other children such as nieces and nephews live with the nuclear family is uncommon among participants and informants in this study.

These urban residential patterns and household arrangements have effects on gender roles and the division of labour in the household. Depending on the form of accommodation, men are willing or not willing to perform housework such as cooking, cleaning and washing. Couples in the second and third groups have more gender fluid roles as men are more willing to perform household chores because of the enclosed housing. For example, Hannah, one of the key informants lives in Nungua, a suburb of Accra, with her husband. Their apartment is in a big compound house but it is private and enclosed, and they do not share any facility with others on the compound. According to Hannah:

You see where we live, whatever we do indoors, no one sees. When I was pregnant, I couldn't do anything. My husband woke up early in the mornings to clean the room when it was dirty, cooked and made sure things were ok with me before he

left for work. When it came to washing, he washed in the kitchen and then I dried the things later. It was only once that I was washing outside and he came out to help me. When people see this, I know they will mock him but I will say it is all love (Hannah, 19th July 2012, Accra).

Couples who live in compound houses and share facilities such as toilet, kitchen, bathroom and verandas with others are not likely to have male partners perform household chores. This is because the society has not accepted men's performance of household chores. Men who perform these duties are nicknamed "woman-man", "kotoboku", "otoolege" (fool), "Salomey" (A man who lives in a woman's house and therefore is controlled by the woman), among others. This is similar to findings in Nepal where men who perform household chores are stigmatized (Mullany et al., 2005 and Mullany, 2006; See also Cornwall, 2003).

Some women are also accused by extended family members and other people for putting spells on their partners and turning them into fools. For example a woman in a focus group discussion had this to share:

As for my husband, he does everything for me. He fetches water, does the cooking, washing, everything. Because of this, people said I had turned him into a slave. So I had to move to come and stay with my mother because I cannot do anything and if he does it, people say all sort of things (Woman, FGD 2, 24th July 2012, Accra).

This case illustrates women's desire to protect their husband's reputation. Such accusations also make some men reluctant to be seen performing these tasks even when they know they have to. For example:

My husband does everything; he shops and cooks but as for washing, he will never do it. Even when he has only one dress left, he will wear it and refuse to wash. So the clothes get heaped in the room. What I usually do is to dedicate a day to washing. Afterwards I become ill but he won't do it for people to see him sitting outside and washing (Woman, FGD 2, 24th July 2012, Accra).

In dealing with this situation, most women suggested that women should keep their partners' performance of housework private. If you do not live in a private apartment, as a woman you could divide household chores so that your husband performs the tasks which are indoors like cleaning the room, ironing and carrying the baby. The woman then performs the outdoor tasks, such as cooking, shopping, and cleaning the bathroom.

In addition, women could make their partners perform housework when other people are not watching. No matter how supportive your husband is, when your in-laws visit, you should not let him perform certain chores because this could incite jealousy and other accusations. A woman shared an example during a discussion:

I have a neighbour whose husband is very hardworking and supportive. However, it seems she takes things too far, whether she is pregnant or not, she makes her husband do most of the household duties. Instead of seeing his performance of these tasks as a form of support, she sees it as the man's duty. She makes him perform these tasks publicly and does not care who is watching. Other neighbours always talk and complain about how she treats her husband. You see, if you treat your husband like this and his sisters or mother sees it, they will definitely not be happy. If I were the sister of this man, I don't think I would be happy at all (Woman, discussion at pregnancy school, 25th August 2012, Accra).

This example also illustrates that some of my participants similar to other participants in studies conducted in Ghana see men's performance of household tasks as a form of assistance and not a responsibility (Boateng et al., 2006). However, women's work situation could influence men's performance of household tasks. First, when both men and women work, they may have more resources allocated for accommodation which could facilitate husbands' performance of housework. At the same time when both men and women work and contribute to household resources, they may also perform housework together. The next section examines how women's participation in the labour market influences gender division of household labour.

6.2 Work and household division of labour

Women's participation in the labour market is not new in Ghana. Historical studies conducted in Asante reveal that women since the 1920s have been involved in cocoa farming, trading and practising some vocational skills (Allman, 2001; Allman and Tashjian, 2000). This made women autonomous in marriages and in the society. Nevertheless, men remained the expected providers of the family's economic resources (Clark, 1999; Boni, 2002). By the late 1970s, economic crisis in Ghana caused women to supplement their husbands' contributions while men also performed some housework (Clark, 1999). Recent evidence shows that women contribute as much as men to household finances (Oppong, Badasu & Wærness, 2012). My study related women's work outside the home, for example as civil servants or working in the informal sector as traders, hairdressers among other occupations, to men's performance of housework, especially, when the family is expecting a baby.

Most participants in my study work in the informal sector as traders, hairdressers, dressmakers, carpenters, salespersons, drivers and caterers. Few work in the formal sector. Others, though educated or trained with vocational skills, are not practising their professions. It should also be emphasized that none of the participants mentioned housework as "work". Nevertheless, some women were of the view that since they work and their husbands also work, they should share household duties, especially during pregnancy. For instance, in Accra, people spend long hours in traffic, consequently, the partner who arrives home first does the cooking. For example, Dede is a secretary and her husband is a marketing manager. They belong to the third category of housing situation described earlier; they live in a private apartment. Dede explained how her work schedule is equal with her husband's and therefore they share household responsibilities.

These days both partners work so men should be more active in helping the woman in the house. They shouldn't think it is not their responsibility. Sometimes you come back from work tired and you don't feel like cooking. Sometimes my husband arrives home earlier than I do, he can't wait for me to return and come and cook when I am equally tired as he is (Dede, 19th July 2012, Accra).

Kate, a hairdresser married to a driver said similarly:

These days there are no chores for men and no chores for women. We both work and when we are living together, we do it together. When we wake up in the morning getting ready for work, while I prepare the food for the children, he baths them. When we return in the evening he helps to pick things up for me while I cook. If he returns earlier, he cooks. So we basically do everything together (Kate, 18th July 2012, Accra).

Kate and her husband belong to the second category of housing situation, having a private kitchen and bathroom with a shared compound. Even though Kate stated that she shares household activities with her husband, washing was not mentioned as one of the tasks performed by her husband. This could be so because washing takes place outside and others will be watching.

Household duties are performed also according to the proximity of workplace to the house. Some women, who are self-employed such as seamstresses, caterers and hairdressers, sometimes have more flexible working hours; some have their shops close to the house. In such cases, they perform household chores not necessarily because they are women, but because it is easier for them to do so. When men are self-employed and work from the house or closer to the house than their partners, it is common that they perform most of the household duties. For example Enoch, who is an engineer, and lives in his own house, performed some household tasks when his wife was pregnant because his work schedule is flexible. According to him:

I work on shifts. Sometimes I am on morning duty and at other times, afternoon duty and other times night duty. So when I do not go to work in the morning and afternoon and I am at home, I do the cooking, washing and cleaning (Enoch, 19th July 2012, Accra).

Clement, a 26 year old carpenter also performed housework because he worked at home. Clement's partner is a 20 year old student. She became pregnant and had to take leave of school for a while. Throughout her pregnancy she did not engage in any economic activity. According to clement:

We have household chores for women and we have household chores for men. For instance, a woman has to wash, cook, take care of the children, and fetch water if the children are not old enough to do so. But for me, I work at home so when it is time to wash, I don't let her do it alone. I wash with her, as for water, I fetch it always and when she is not at home I do the cooking (Clement, 2nd August 2012, Accra).

This shows that for a man like Clement, household chores are a woman's duty, but because he works at home, he decided to do it. Clement and his partner belong to the first category of housing situation and he lived alone until his partner became pregnant and had to move in. Clement also acknowledged that the society does not approve of men performing housework:

...but some people say the woman has the man under control. Others will also say you are a fool, how can you go and work and bring money home and at the same time perform household activities. If you listen to such things, you will stop but if you love your wife, you will keep doing it (Clement, 2nd August 2012, Accra).

It could also be stressed that Clement performed these tasks because of his wife's pregnancy as he later indicated:

When the child is old, she has to perform her household duties. If I work and bring money for the family's upkeep, then I expect her to also do what she has to do to maintain the house. Take care of the children and make sure they do not take up bad behaviour. If I am at home and can help, fine, but if I am not, then she has to do it. If she does not work and I keep doing these things, then people will have a point when they say I am a fool (Clement, 2nd August 2012, Accra).

This assertion by Clement was also affirmed by most participants in focus group discussions:

When you sit at home and your husband alone goes and come (work), he provides everything for you and the house, then you should not expect him to come home and do the housework too. That will be very bad. Being in the house and not helping your husband is not good. As a woman you must also work and contribute,

else what will happen if the money gets finished or if something happens to his job (Woman, FGD 3, 25th July 2012, Accra).

These assertions show the correlation between work, especially, women's work outside the home and men's performance of housework. Both couples could be educated, but when the woman is unemployed, it is not expected of the man to perform housework. Similarly, both couples could be uneducated but when they both work outside the home they tend to share housework depending on proximity and flexibility of their schedule. However, during pregnancy and childbirth, men like Clement perform most of the duties as a form of love and protection of their partners. More examples of this protection will be discussed later in the section on fathering and mothering.

6.3 Extended family relations

The nuclear family structure is becoming more common than the extended family where couples live either with the man or the woman's family (Kwansa, 2012). As already indicated, most participants in this study live in a nuclear family structure. Previously, when a woman living separately from her parents was pregnant and was about to deliver, she would go and stay with her parents until the baby was a few months old (Badasu, 2004). This had reasons such as family planning and because older female relatives are believed to be more experienced in maternal healthcare (Jansen, 2006). However, due to modern family planning methods and antenatal and postnatal clinics, women are no longer required to leave their husbands. Nevertheless, first time mothers sometimes need the support of extended family members. In such cases, they either leave their husbands for a few months or invite an extended family member, usually the mother or mother-in-law, to stay with the couple. Inviting an extended family member depends on whether the couple can accommodate them.

Kin support in maternal healthcare, either the mother or mother-in-law moving in with the couple or the woman moving in with the kin, has some challenges. From women's account it is better for their mothers or mothers-in-law to move in with them. This is first of all due to the fear that their husbands could become promiscuous. Some women contend that some men cannot abstain from intimacy for long periods of time

and in this regard, it is better to stay close and “manage them like that”. But when the housing situation is not good enough to give a separate room to mothers or mothers-in-law, then women are forced to move out for a while.

Men also do not like the idea of their wives moving. They want to be part of the process and support their partners in their own ways. They want to see what happens to their wives and babies every day, and help them make critical decisions. This is linked to an idea of protection during pregnancy and childbirth; that women are vulnerable during this period and have to be protected. For example David said:

I cannot allow my wife to stay with her mother or away from me because I have to make sure my wife is ok. I have to see her every day and if there is something I can do to help, I do it (David, 26th July 2012, Accra).

However, some men compromise when they do not have good accommodation for their mothers-in-law. This was the case of Clement who had to allow his partner to stay with her mother because of inexperience with children as well as inadequate space to accommodate his mother-in-law. Clement said:

When she (partner) gave birth, she went to stay with her mother for a while because my wife is very young and inexperienced. She is only 20 years old. She could not bath the baby so I had to ask her to go and live with her mother so that her mother could help. You see at the beginning she could not even fix the baby’s diapers and was even afraid when carrying the baby. But now she is picking up. Now she has returned and is living with me. But when she was with her mother, I went there every morning and every evening. Her mother does not live far away from us. I was going there to see the baby every day to make sure he is fine and so that when he falls sick, I will be there to help (Clement, 2nd August 2012, Accra).

Nevertheless, most men and women agreed that it is better to have someone come over than the woman moving out. Who then should it be? Usually, the mothers of women are preferable. Most women said they are able to communicate with their mothers better than their mothers-in law, especially regarding instructions concerning health practices such as breast feeding, eating habits among others. When their own

mothers give advice contrary to medical advice, they are able to correct them. However, when a wrong advice comes from a mother-in-law, it is difficult to discuss and correct. For example, during an observation at the health facility, there was a case in which a baby had developed a swollen thigh resulting from vaccination against tetanus. The nurse midwife asked the mother of the baby how it happened. According to the mother, after vaccinating her baby, her mother-in-law asked her to use warm water to massage the sore. Even though she told her the nurse-midwife said she should only rub her fingers on it, her mother in-law insisted and because she could not disobey her, the baby developed a swollen thigh. This case is similar to Jansen's (2006) study which indicated that younger women are not expected to explicitly disobey older female relatives when they give instructions related to pregnancy and childbirth. This is because older female relatives are regarded as knowledgeable in maternal healthcare because of their experience.

In addition, extended family members, especially, mothers and sisters-in-law, could physically and emotionally abuse women and men. A nurse-midwife shared how a mother-in-law abused and subordinated her daughter-in-law:

No more mother-in-law or sister-in-law. They come and bring problems. I had a case here, where the mother-in-law asked the pregnant woman to fetch water for her to bath. Meanwhile there is a pipe in the house and she only needs to go and get the water but she will not. So this girl had to carry a bucket fetch the water and put it in the bathroom for her mother- in-law. At night, the mother-in-law will sleep on the bed and the pregnant woman will sleep on the floor. So this girl came to me crying and said she does not want the woman to be there when she delivers but her husband said that she is his mother so she has to comport herself (Nurse-midwife, 30th July 2012, Accra).

Whereas female partner family may not physically abuse male partners, they could emotionally abuse men, for instance by demanding money and insulting male partners. From the experiences of some women, staying with their family creates dependency on their partners. Their partners become the providers of their extended family. Mothers and sisters keep demanding for money and other things and when

their partners are not able to provide, they disrespect them and question their manhood, by making statements like “is this your husband a man at all” (Woman, FGD 3, 25th July 2012, Accra). This sometimes makes the woman uncomfortable and could create problems in her marriage.

Moreover, some men feel marginalized in the presence of their mothers or mothers-in-laws. Some men say that mother-in-laws come around and take charge of their homes and give instructions, relegating them, “the heads of the household”, to the periphery. It also reduces the level of intimacy with their partners. In this light, men prefer to support their partners solely, especially when it is not the first time the couple is pregnant.

6.4.0 Fathering and mothering

This section discusses how women’s participation in the labour market and the dwindling of extended kin relations expand the expectations of fatherhood and motherhood. Fatherhood and motherhood define the core responsibility of men and women in the household and reflect the division of household chores between couples. Notions of fatherhood in Ghana revolve around three main roles; the father is the father to his wives’ children, he provides for the house and protects his wife and children (Agorde, 2006). Some notions of motherhood in Ghana include performing household duties, caring and feeding the family and caring for the health and education of children (Clark, 1999; Badasu, 2004; Jansen, 2006; Sossou, 2006; and Tolhurst & Nyonator, 2006). Narratives and discussions in this study reflect notions of fatherhood and motherhood closely related to the above. Additionally, women’s participation in the labour market and the dwindling of extended kin are changing these notions of fatherhood and motherhood which in turn shape the gender division of labour plus men’s participation in pregnancy and childbirth.

6.4.1 Provision for the household

According to participants, a responsible father is one who takes care of his wife and children, and plays a leading role in providing for the family financially. A mother also plays a supporting role financially and keeps the home. Some male participants

contended that since it is a man who takes the initiative to marry a woman and not otherwise, it is a man's duty to provide. According to Enoch, "the woman was there and you went to marry her so you have to take charge and make sure she is ok at all times" (Enoch, 19th July 2012, Accra). Women also referred to a father as "one who provides for a woman's upkeep and makes sure she attends the clinic, be by her side, helps buy things in preparation for the baby, and pays the school fees when children are grown to start school" (Woman, FGD 1, 17th July 2012, Accra). In this regard, when the family is expecting a baby, the first role of the man is his financial contribution. He provides money for healthcare services, food, buy baby products and money for the naming ceremony. This view has also been expressed in other studies in Ghana (Clark, 1999; Boni, 2002; Badasu, 2004; Jansen, 2006).

A mother's role is "taking care of children, preparing them for school in the morning, cleaning the house, cooking and ensuring the house is in order" (Woman, FGD 4, 25th July 2012, Accra). At the same time, most participants said that the working situation of women is changing and therefore when a woman works, she can also contribute. For instance,

In this modern Ghana that we are, it is the case that the man's contribution is more but as the woman also works, she should contribute. So we all contribute in taking care of the children for a better future. When the man has paid the school fees, the woman should also give feeding fee, provide food at home and bath the children (Woman, FGD 1, 17th July 2012, Accra).

Nevertheless, informants and participants believed that women should not be coerced because it is not their core responsibility. Thus, men should still take the leading role and see whatever the woman does as optional. An example can be seen from this statement:

The man is the head of the family, so the majority of performance comes from the man's side. So if the baby is coming, you have to look after the baby and provide all the financial needs. 98% should come from the man but at times the woman also contributes reducing the man's to 80% (Simon, 17th July 2012, Accra).

Similarly, Tina said that “It should be a mutual understanding. Mostly we discuss. But I do not think your husband should force you to provide for the family. You (the woman) should suggest and support” (Tina, 18th July 2012, Accra). The contribution of wives could vary depending on how much they earn. Thus, even though Simon has indicated that men’s contribution is 80% while women’s is 20%, it is possible that women are doing more than 20%. This relates to Tolhurst & Nyong’oro’s (2006) study that more women are becoming providers of the household. Nevertheless, the expectation that fathers are the main providers for their families still exists. Consequently, informants subscribe first of all to men’s financial role as their main contribution towards maternal healthcare.

6.4.2 Decision-making in the household

During pregnancy, childbirth and the postpartum period, couples are faced with making a lot of decisions. These decisions revolve around women’s health and nutritional needs during pregnancy and childbirth, when to have the next baby and whether the family would need help during the period. Interviews and discussions revealed that such decisions are not unilateral but are discussed by couples.

It has been indicated that some men, as the major decision makers and heads of households, may be reluctant to use scarce family resources on women’s healthcare and nutritional needs (Feldman-Jacobs, Olukoya & Avni, 2005, pp.6-7). This was not the case of participants in this study. Most men and women agreed that they decide together how to spend their resources, what a woman should eat, or that the woman chooses what to eat according to medical advice. Such decisions are also based on who among the couple is more knowledgeable; if the man happens to know a lot about pregnancy then he takes the leading role. Otherwise women, or their mothers and other experienced members of the family take such decisions, mostly based on medical advice.

The number of children in the family, even though it is initially discussed by couples, reflects male rather than female preferences. Couples generally discuss the number of children they want to have in the family, but when they have only female children, then women are expected to try again in order to have a male child. Tina is

trained as a secretary while her husband is an electrical technician. Tina is unemployed and not pursuing her career. This is what she had to share about their decision to have another baby:

We decided to have two children. The first was a girl, the second twins, two girls....but I will have another one...because as for men, their preference is boys so you have to do it to satisfy them otherwise they will not be happy (Tina, Accra, 18th July, 2012).

Hannah is a hairdresser and her husband is a driver. She is not practising her vocational skills. She has had two difficult pregnancies and labour experiences. She shared a similar experience like Tina: “we decided to have two children but I will have another one because my husband says he wants a boy”. Despite Hannah’s previous experience, she is willing to have another baby to satisfy her husband’s desire for a male child.

With regards to family planning, couples decide together. Decisions such as the use and choice of contraceptives and when to have the next baby are usually discussed. Both men and women are sceptical about contraception because of the perceived side effects such as excessive weight gain, heart problems and infertility. Nevertheless, some men and women said that they use modern family planning methods while others said they preferred the natural means referred to by participants as “calendar method”. When some men disapprove of family planning, some women said they would secretly do it without their consent:

But I think you, the woman, has to decide. You see this stomach (pointing to her stomach), immediately the child comes out I am going for family planning.....I don't need my husband's approval; I am the one feeling the pain. It is not good to be going to the labour ward always and children always hanging around you. The man will get up and go and it is you the woman who will feel the pressure most for their upkeep” (Woman, FGD 1, 17th July, 2012, Accra).

Women’s secret use of contraceptives has also been expressed by participants in Sossou’s (2006) study among urban and rural dwellers. However, some participants

in my study said they have to obey their husbands because when they are in trouble it is the husbands who help. Women in this situation may not use contraceptives if their partners disapprove. For example, a woman said:

My husband told me, if you do it (family planning) and something happens, hmmm. So I am not going to do it because if I do and something goes wrong he will say I did not listen to him. It is the men who help us so when they disapprove of something you have to listen, otherwise if it does not go well, you cannot ask them for help (Woman, FGD 3, 25th July 2012, Accra).

These examples about the number of children in the family and the use or non-use of contraceptives show the power dynamics between partners. Surveys from the 1990s in Ghana indicated unequal gender relations in decision-making with regards to fertility, which reflected male rather than female preferences, making women to have more children than they wanted (Baden et. al, 1994, p.47). DeRose et al. (2002) have indicated that Ghanaian men are most likely to dominate decisions about fertility, especially the desire to have an extra child (See also Sossou, 2006; Do & Kurimoto, 2012). Tolhurst & Nyongator, (2006) have indicated that some women prefer joint decision-making in order not to be blamed if the decision produces negative results (See also Mullany et al., 2005).

The 2008 Demographic Health Survey (DHS) indicated that men and women decide together the number of children in the family (GSS, 2009). Evidence from my study also indicates that couples decide together the desired number of children but the decision to have an extra child, usually the attempt to have a male child, is male dominated. Such decision-making patterns, as reflected in my study, could also be related to women's access to economic resources. Women who do not have independent access to economic resources could have less power in participating in household decisions (Kabeer, 2004). This could explain why unemployed women like Tina and Hannah are willing to have another child. Having another child, a male child, could be Tina and Hannah's way of ensuring security and gaining the protection of their partners (Kandiyoti, 1988, p.283). Thus, in such situations where men solely provide for the household, their decisions could be prioritized over women's

decisions. However, it could also be argued that these women are willing to have an extra child because they are not pursuing a career which may interrupt with childcare.

6.4.3 Protection of the family

A father predominantly is believed to protect his wife and children. But what does protection mean during pregnancy and childbirth? In this study, male participants see their partners as vulnerable during pregnancy and childbirth. In addition, some women become ill during the period of pregnancy. Thus, from the narratives of men, pregnancy is a period in which a man should provide his partner with protection and security. Similar to the findings of a study in Nigeria (Odimegwu et al., 2005), men in Accra were of the view that during pregnancy, the woman's health should be prioritized. Accordingly, she should not be allowed to perform difficult tasks such as pounding fufu, fetching water, washing and cooking for long hours. Men said that they cannot bare the pain their partners will encounter if they allowed them to perform difficult tasks. According to Simon:

The most difficult thing is going to the market because shopping, sitting inside the trotro (vehicle/bus), carrying things. I think it is a lot of work. She is hard working and I know if she stops vomiting she will like to do some of these things. But I will not let her because anything can happen. I am not concerned about the money I will spend but the pain she will go through. I have to protect her (Simon, 17th July, 2012, Accra).

Protection is significant in men's performance of housework during pregnancy. Some men even said if they are not used to performing duties such as cooking, they will not mind buying food from restaurants or try to cook. For instance, Clement said:

When a woman is washing with a big stomach and you are watching as a man, it is not fine. You can just take it up and do it. Also looking at the state of her stomach and the pregnancy and you watch while she stands beside the fire and cook for you, it is not good at all. If you have the time, you can just do your own cooking; otherwise you can buy food and eat (Clement, 2nd August, 2012, Accra).

Protection also relates to the notion of the couvade as discussed by Middleton (2000). Among the Karembola, men are expected to perform household duties and

refrain from sexual activities during the postpartum period as a way of nurturing the mother and baby (Middleton, 2000, p.117). In the case of the Karembola, this was a way of showing how men give life to their children and also claiming relatedness (Middleton, 2000, p.117). In my study, according to participants, men's performance of household tasks during pregnancy and the postpartum period is a way of showing compassion, sharing the burden related to reproduction as well as protecting their "blood". However, it could also be interpreted similar to Middleton's (2000) study that men's performance of housework is also a way of some men claiming relatedness and practising fatherhood. This is because previously it was enough for a father to provide for the upkeep of mother and child, like paying medical bills, buying clothes, providing food and shelter. While housework, antenatal and postnatal care was reserved for mothers and the matrikin. Now, providing for the household is a shared responsibility between mothers and fathers. Moreover, kin support during pregnancy and childbirth has dwindled, especially, in the urban context. In this case, fathers have to do more to show relatedness by performing housework and participating in antenatal and postnatal care.

6.5 Changing gender and household relations and their implication for maternal healthcare in Accra

In Ghana, social expectations and the definition of tasks categorize men as leaders, providers for the family and decision-makers, while women are expected to perform household duties such as cooking, washing and caring for children and the aged (Adomako-Ampofo, 2001). The evidence provided in this chapter shows that gender relations in the household are changing. Dominant notions of gender practice are altered in marriages, especially, during pregnancy, childbirth and the postpartum period. Some of these changes could be related to the visibility of women's labour and contribution to the household as well as the dwindling of kin support in maternal healthcare (Kabeer, 2004; Kwansa, 2012). For instance, mothers who work are expected to provide for the household. Thus, fathers are influenced to go beyond the provision of household resources to perform household tasks regarded as "women's work".

Even though dominant gender roles are altered during pregnancy and childbirth, the idea of gender specific roles in the household persists. This is exponent in the definition of fathers as the main providers for their families while mothers are expected to perform housework. In this regard, men's performance of housework or women providing for the household is seen as a form of assistance and not a core responsibility. It is also due to the persistence of gender specific roles in the household that men who perform household tasks are stigmatized and nicknamed "woman-man" among others. This form of stigma does not only relate to the power relations which persist between men and women, but that which persists among men. In such cases, men who perform household duties are viewed as subordinate to other men who do not do so (Connell, 1995). Similarly, men who are unable to provide for their families are seen as not "real men", thereby regarded as not living up to the hegemonic model (Connell, 1995). To deal with subordinate masculine models, couples avoid kin during pregnancy and childbirth to prevent extended family members from questioning the manhood of the male partner. Couples also divide household chores so that men perform tasks which are indoors while women perform tasks which are outdoors to avoid social stigma.

Thus, various masculinities can be seen as interacting in this chapter, for example, subordinate forms can be seen engaging with dominant forms. As these interactions unfold, the practices of men and women could be regarded as complicit in the framework of Connell (1995). For instance, the practice of men and women sharing housework according to which one is public or private relates to Connell's notion that emphasized femininity is mostly "linked with the private realm of the home and the bedroom" (1987, p. 187). Thus, men and women could be described as complicit because even though they may not support dominant social models of masculinities and femininities, they do not openly disregard what the society expects (Connell, 1995; Demetriou, 2001; and Lusher & Robins, 2009).

Couples constructing complicit masculinities and emphasized femininities could also be explained as a form of emotional, material and social investment "which are the reward of the senior man, the good wife" or the good father and the good

mother (Moore, 1994, p.65). While men performing household chores could be individually satisfying, doing so could be at the expense of social approval and the reward of the senior man and the good wife (Moore, 1994, p.65). As a result, men and women may comply with dominant gender roles in order to gain social acceptance.

6.6 Chapter summary

This chapter has examined how three main factors; housing arrangement, women's participation in employment outside the home and the dwindling of kin in maternal healthcare, shape men's performance of housework and their participation in pregnancy and childbirth. Evidence provided has shown that dominant gender roles are altered during pregnancy and childbirth and that some men perform tasks such as cooking, washing and cleaning. As these changes unfold, men and women could be described as complicit with hegemonic masculinity by protecting men from social stigma. The next chapter moves beyond the household to discuss men's presence and support at antenatal clinics, delivery rooms and postnatal clinics.

CHAPTER 7: PATERNAL INVOLVEMENT IN ANTENATAL, DELIVERY AND POSTNATAL SERVICES

7.0 Introduction

Men's attendance at antenatal and postnatal clinics is a recent phenomenon in Ghana. Margaret has practised as a community health nurse for twenty years and as a nurse-midwife for eleven years in Accra. According to Margaret, when she started practising as a community health nurse it was difficult to convince women to attend antenatal and postnatal clinics because they did not understand the benefit of such services. Therefore, community health nurses visited mothers at home to give advice and immunize children. Now, however, women understand the need to attend antenatal and postnatal clinics. When Margaret began her practice some thirty years ago, it was rare to see men at the antenatal or postnatal clinic. These days, there are a few men who accompany their partners to antenatal and postnatal clinic, and most women are accompanied to the hospital by their partners during labour. These partners stay in the waiting room but do not usually have the opportunity to witness the birth of their children.

Some literatures have indicated that fathers' involvement in pregnancy and childbirth, such as attending antenatal and postnatal clinic or staying in the delivery room during labour and delivery, could produce positive health outcomes for the father, mother and child (Dellman, 2004; Plantin, Olukoya, & Ny, 2011). Examples of these health outcomes include healthy live birth, decreased possibility for low birth weight and reduced premature birth among others (Carter, 2002; Alio et. al, 2011). This chapter discusses the significance of men's attendance to antenatal and postnatal clinics, men's attitudes towards the clinic as well as their experiences of labour and childbirth. The chapter discusses the wider implications of men's participation such as gender division of household labour and partnership in maternal healthcare. The chapter ends by discussing how social constructions of masculinity impacts men's role at the clinic and during childbirth.

7.1.0 Antenatal and postnatal clinic

Antenatal clinics in Ghana are organized for expectant mothers from conception until childbirth. The postnatal clinic is organized for mothers after delivery, from the first day of delivery until six weeks afterwards. Mothers have appointments with doctors and nurse-midwives. While the antenatal clinic at the Police Hospital usually takes place on Tuesdays, the postnatal clinic takes place on Wednesdays. About 200 women could show up in a day and some women have to report as early as 6am in the morning and may spend about three hours at the clinic. The clinic does not start before 8am; but due to traffic situation in the city, women have to leave their homes by 5:30am. When they arrive at the clinic, they have to wait in a queue until 7am when the records session of the hospital opens to pick up their health information folders, and then they return to the clinic to wait until 8am before activities start. There is a waiting space where activities begin with a prayer and worship session led by hospital staff such as nurses, midwives and nutritionists. After the worship session, a nurse or nurse-midwife or nutritionist leads a general discussion about eating habits, breastfeeding, buying items for delivery, labour signs, contraception and intimacy during pregnancy and after childbirth. Then women have to queue to have their blood pressure and weight measured. Finally they queue to see a nurse-midwife or doctor for other specific examinations.

7.1.1 The significance of men's presence

As this section will illustrate, men's visit to the antenatal and postnatal clinic is regarded as important in four different ways; to facilitate financial support, to serve as reminders and correctors, for respect, and for support and protection at the clinic. First, men's visit to the clinic could help to prevent men from complaining when women demand money for antenatal care. According to some women, men are often reluctant to give their partners money for antenatal care because of Ghana's free maternal healthcare system. Some men think everything is free, consequently, when their partners are coming to the antenatal clinic they only give them money for transport. This sentiment was first encountered during an observation at the antenatal clinic when a nurse-midwife was advising expectant mothers to save money and also ask their husbands to support them to buy things which they will need during labour and

delivery. A list of items required during labour and delivery is usually given to women on their first antenatal visit. This list includes a bag/suitcase, pads, disposable pants, antiseptic, gloves, detergents and other toiletries.

During a discussion between the nurse-midwife and expectant mothers, one woman said:

These days the men think everything (maternal healthcare services) is free so when you tell them you need money for such things they don't mind you or they think you just want their money. So they just give you five Cedis (\$2.5) for transport and that's all. If they could come themselves, it would be good.

This sentiment generated laughter and argument among the women and when the nurse-midwife asked if it was true, the majority responded in the affirmative. Similar issues were mentioned in interviews as the reasons why men should attend antenatal clinic. According to Tina:

Maternal healthcare services are free but when they check your BP you pay, medicine you pay, everything you pay. That worries me..... If your husband is somebody who does not understand, he will be upset. Every day he looks at the health insurance card and yet he has to give you plenty of money for healthcare services. But if he comes with you, at least once, then he will understand why you need more money (Tina, 18th July 2012, Accra).

These views were affirmed by Simon's statement about his changed financial situation which he relates to what he heard at the clinic.

I am sacrificing myself. And I know I have to do more, as the man, when the baby comes. The doctor advised me the other time when we came to the hospital that I will spend a lot so I should just take things easy (Simon, 17th July 2012, Accra).

These views re-emphasize fathers' role as the provider of the family and relates to indications in some of the literature that women are able to collect money from their partners during this period when the partners are aware of the need (Carter, 2002a; b). Some men also seem to change their expenditure during pregnancy because of their

role as fathers. According to Enoch, “I had to economize my money because of the baby. So now I have limited myself on how much I have to spend on other things”.

Another reason why women find it important that men attend antenatal clinic is to hear and understand the instructions of nurse-midwives with regards to issues such as exclusive breastfeeding and women’s physical activity during pregnancy. A nurse-midwife said:

There is a difference between women who have their husbands concern and women who do not, because when women do not get it right, their husbands will correct them. There was an incident when we advised mothers to give their babies only breast milk “nufu nsuo” but the woman heard it as sea water “epo nsuo”. So when they went home she started talking about it and then her husband corrected her that it was not “epo nsuo” it was rather “nufu nsuo”. So you see these are some of the things (Nurse-midwife, 30th July 2012, Accra).

In this example the man acted as a corrector to his partner. The example is also similar to findings in Nepal (Mullany, 2006) which have shown that when men accompany their partners to the clinic, instructions received are more likely to be performed than when women receive such instructions alone. This was related to the view that when women communicate to their partners, men delay in carrying out the instruction because they do not understand its importance (Mullany, 2006). Thus, men could suggest alternative means like visiting a different health facility or using the services of traditional birth attendants (Mullany, 2006). Similarly, some participants in my study mentioned that some men are reluctant to take instructions from their partners. According to Tina:

If it could be compulsory that when you are coming for antenatal you come with your husband, it will help. Even if not always, at least, four or five times before delivery, it will help. At least, when they come and the midwife says something, they will pick it up and when you say something they will understand. You see there are some men who are very stubborn and when you go home and you say something, they think it is because you are lazy. So when the midwife says it and they hear it

themselves, then, things will change and they will give you the necessary support (Tina, 18th July 2012, Accra).

A participant in a focus group discussion also had this to share:

Sometimes when you go home and say that the doctor says do this or that, maybe carry the baby like this, do not give him this he (partner) will not understand. He will yell and shout at you thinking you are telling lies. But if he comes and hears it with his own ears, then he will do as advised. When I came for postnatal the first time, he (partner) came with me. At the clinic, the nurse-midwife advised that I should breastfeed the baby for six months, no food, no water. When we went home, he told me, did you hear what the nurse said...huh, make sure you do accordingly. If I said this to him alone, I know the response would have been different. The first time we realised I was pregnant, he came with me. After the scan, the doctor told us that now that I am pregnant I have to eat well, fruits, vegetables etc. So throughout the pregnancy, I will tell him, as the doctor said (laughing), I have to eat this and he will provide money for it without complaining. If I came alone, he would not have understood and would have said I was lying (Woman, FGD 3, 25th July 2012, Accra).

In addition to fathers acting as correctors and reminders, these examples show how gender hierarchy and power relations interplay during pregnancy. As illustrated in the quotes above, some men are reluctant to take instructions from women even concerning women's own health. Therefore, some women find it better that instructions about their health are communicated directly to their partners. Similarly, a study in Tanzania has revealed that it is culturally unacceptable for men to take instructions from women (Falnes et al., 2011). Some men's reluctance to take instructions from women may partly be due to cultural expectations and women's ability to negotiate and participate in household decision-making. This could also be related to the economic situation of these women who have to depend on their partners for food and other resources, thereby having less decision-making power than the men.

In addition, some women would like their partners to attend antenatal clinic with them because they will be prioritized over other women as well as be treated with

more respect than other women. The hospital has an arrangement of attending to pregnant women who attend antenatal and postnatal clinic with their partners first (this arrangement will be discussed in detail in the next chapter). Therefore, women who are accompanied by their partners spend less time at the antenatal clinic. As already mentioned, due to the large numbers, overcrowding occurs in the waiting space and some women have to stand for a long time. While waiting, nurse-midwives could yell at some women. Simple instructions could be given out in unpleasant ways. Women often do not have an opportunity to ask questions about their reports and test results. Consequently, some women said that when they attend the clinic with their partners they will be treated better because the society has more respect for men than women. Thus, when a man asks questions concerning the health of his partner, healthcare providers are unlikely to yell at him. This view was expressed in focus group discussions. For example, a woman said: “Well you know that usually men are given more respect, so maybe because they are shy of the men and knowing that men will not like to be yelled at, they will not do it” (FGD 1, 17th July 2012, Accra).

Another woman, supporting this claim, affirmed: “because as she has said, everywhere you go, when you are with a man, you have more respect because people know that men don’t take it lightly when they are insulted or shouted at” (Woman, FGD 1, 17th July 2012, Accra). This is similar to findings in Nepal (Mullany, 2006) which indicated that husbands’ presence could improve interactions between doctors or nurse-midwives and women.

Informants and participants also agreed that men’s attending antenatal clinics is a form of support, to help your partner go through the period. They affirmed that it is one of the things that a man can do to show that he is also expectant. For example, a woman said:

It also shows how much you love your wife. You see, I am not feeling well today. I do not know whether I will be admitted or not. I do not know whether the money I have is enough or not. Perhaps they will ask me to buy some drugs which are not here. If he came with me, in case I am admitted and I need some items, he can go

home and get them for me. If I need to buy some drugs, he can run and get them for me (Woman, FGD 3, 25th July 2012, Accra).

Angie had a similar experience but fortunately her husband was there.

My husband came with me only once. I came only for antenatal and suddenly my bag of water burst. Immediately I called him and he helped the nurses take me to the labour ward. He waited outside and called my mother to bring me some things (Angie, 18th July 2012, Accra).

Some men also see this support as a form of protection that they give to their partners. They see women as vulnerable and should not be left on their own. Either they (men) come or their mothers or a member of the family accompanies women to the clinic. For instance, Simon sees this role as a form of protection. He said:

The pregnancy is only four months but since the beginning I have been coming to antenatal with her. In as much as I want to know what is happening at the antenatal clinic, I also want to be around and protect her (17th July 2012, Accra).

7.1.2 Men at the clinic

Even though informants and participants agreed that it is important for men to attend the clinic, few men show up at the clinic. Some men who attend the clinic wait for their partners in the car, some sit with earphones listening to music or radio while others hang around in the waiting space. Others help to carry the baby or their partner's bag and participate in the discussions at the clinic. There was a discussion about breastfeeding at a postnatal clinic between a nurse-wife and mothers. A man who happened to be the only man seated among the women was carrying an older daughter and his wife's bag. The nurse-midwife asked the women to explain the best way of breastfeeding a baby. The man offered to explain, and according to the nurse-midwife, he was correct, and subsequently applauded by all. It was also observed that healthcare providers engaged men in the discussions to make them feel part of the process.

Others also support their partners with some of the proceedings at the clinic such as picking up their folders from the records office. This was observed as well as mentioned in an interview with Simon:

I go sometimes with her to see the midwife and we also go to the lab together. Sometimes I go to the records office to pick her file and ask questions even before showing up at the antenatal clinic. The other time I was sitting here and the midwife asked whether I was with them and I said yes. Then she asked me, “where is your wife? Bring her so she could be attended to”. Another time, my wife went to take a sample of her urine, so I had to take her file when they mentioned her name. Then the midwife mentioning the names and the pregnant women laughed and asked whether I was also pregnant and I said yes. (Simon, 17th July 2012, Accra).

Comparing men’s attendance at the antenatal and postnatal clinic, it was observed and confirmed in interviews that more men show up at the postnatal than the antenatal clinic. Interviews with healthcare providers revealed that men are more interested in knowing about the baby’s health and how to take good care of him/her. Also, the postnatal clinic is where women are advised and counselled about family planning methods as well as when to begin intimacy with their partners, matters which are of interest to some men. According to a nurse-midwife:

With the postnatal clinic, some do come with their partners because they are interested in the health of the baby. They want to know what the child should eat, what the mother should eat and most important when they can start having sex with their partners (Nurse-midwife, 30th July 2012, Accra).

Another healthcare provider said:

Some women use pregnancy and childbirth as an excuse to avoid intimacy with their partners. I advise women to go onto family planning as soon as possible. After childbirth, some of these men come to the clinic with the women to find out and also seek help with family planning. Most of the times, family planning is initiated by the men (who accompany their partners to the postnatal clinic) so they can start having

intimacy and avoid unwanted pregnancies (Community Nutritionists, 23rd July 2012, Accra).

Thus, men often attend the postnatal clinic to listen to medical instructions about their babies as well as take contraception decisions with their partners. Men's interest in the postnatal clinic could also be explained in terms of fatherhood, in the sense that perhaps they do not fully realise that they are fathers until the birth of the baby. Thus, whereas a man may not see the reason why he should accompany his expectant partner to the clinic, the birth of the child tells him he is now a father and as part of playing his role, he accompanies his partner and child to the clinic.

Men's participation in antenatal and postnatal clinics could also be related to the trust they have in the medical system and the experience of the partners. Observation at the clinics showed that men who are likely to attend the clinic and support their partners through all proceedings were mostly first time expectant/fathers. Some of these men were young and also married to young women with low formal education and little experience with pregnancy and childbirth. This was the case of Simon and Clement, two key informants of this study. Some men in this regard could fear that their inexperienced partners may not properly understand medical instructions. Thus, they, as the men and "head of the family" felt they had to participate in the process, ask questions, understand issues properly and explain to their partners. Multiple time fathers on the other hand perhaps are trustful that the medical system could meet the needs of their partners. Since their partners might have been through the process previously, they were assured that they would be well taken care of.

7.1.3 Men's reluctance/inability to attend antenatal and postnatal clinics

Two reasons explain the reluctance and inability of some men to attend antenatal and postnatal clinic; some men view the antenatal clinic as women's space and some men have unfavourable work schedule. The first reason mentioned by participants and informants explaining men's absence at the antenatal and postnatal clinic is the definition of these clinics as women's space. Some men are shy and do not

want to be seen seated among women. This was the case of Halima's husband. She said:

My husband is very shy. When I was pregnant, I came to the antenatal clinic with him once and he never came again. When we were returning home he told me that if he knew there would be many women here, he wouldn't have come (Halima, 19th July 2012, Accra).

Shyness, as experienced by Halima's husband and other male partners, could be explained in three different ways. The first is that some men are shy to be the only man seated among a large number of women. The second explanation has to do with the type of issues discussed at the antenatal and postnatal clinics, mainly women's reproductive health issues like vaginal hygiene, intimacy during pregnancy among others. Some men are uncomfortable listening to women discuss such issues. The third is related to social stigma. Some people in the society may laugh at men who participate in antenatal and postnatal care which society has defined as women's space. It is similar to the discussion in the previous chapter about how men who perform household duties are labelled "woman-man". Thus, some men may find attending these clinics a treat to their masculinity.

Some of these explanations of shyness were implied in David's statement:

It is only today that I have stayed with her (wife) at the antenatal clinic for the whole day. We were both sitting at the same place and we were discussing some things about ourselves. Immediately the women started coming, I stood up and went to sit elsewhere....I was shy as the only man sitting among women. I felt they were coming to discuss women's issues and I should excuse myself until they were done. (David, 26th July 2012, Accra).

Shyness as David mentions here could be explained by being in a minority and his unwillingness to listen to some of the reproductive health issues to be discussed. Shyness could also explain why some men who attend the clinic with their partners do not sit among the women; rather they prefer waiting in their cars outside or just walk around while their partners are in the queue like the case of David. The definition of

antenatal and postnatal clinics as women's space is widespread in other parts of the world (Leavitt, 2009; Njunga and Blystad, 2010; Tweheyo et al., 2010; and Nkuoh et al., 2010; Dolan & Coe, 2011; and Falnes et al, 2011).

Despite the dominance of shyness from the narratives of informants and participants, time was identified as a stronger factor in this study, especially because there is no paternity leave in Ghana. For example, even though David was able to stay with his wife once during antenatal, he mentioned that on other occasions, he only had to drop her or could not attend at all because of his work schedule as a driver. Similarly, some women said it is difficult for men to attend because of the hours they have to spend at the clinic at the expense of their jobs. For example:

If you both come here, you can miss about 20 Cedis (10\$) a day for not showing up at work, since we spend a lot of time here. Even just picking the folder takes five hours (exaggerated) (all laughing). So there are some men who will get angry with you if you keep them here for so long. Imagine him leaving his work for the day and wasting the whole time here (Woman, FGD 1, 17th July, 2012).

Since the antenatal and postnatal procedures cover several hours in a day, some men are reluctant to attend, especially, when their work schedules are unfavourable. Informants like Clement and Enoch mentioned in the previous chapters are able to attend the clinic sometimes because of their work schedule. Clement, for instance, works at home and on days that he is less busy, he decides to attend the clinic while Enoch works on shifts, so when he is not working in the morning, he can attend the clinic with his wife. Moreover, men's role as the providers for the family is sometimes prioritized over their presence and support at the clinic. For instance, a woman in a focus group discussion said: "he is going to bring you money and you are expecting him to come to the clinic? Ei, no!" (Woman FGD 3, 25th July 2012, Accra). The work situation of men discussed in this section relates to arguments that men are not the only problem but employers and hospital policies should also be considered in the agenda to involve men (Carter, 2002a; UNFPA 2004; 2007; 2010; 2011).

Though some men do not show up at the clinic, they communicate with their partners and healthcare providers about how their partners and babies are doing. Most of the women informants and participants in the study affirmed that their partners are unable to attend antenatal clinic due to their work schedule. However, their partners asked them questions when they returned home from the clinic. Some men also write notes to the healthcare providers or request for their contacts and called to ask how their partners are doing. This was confirmed by healthcare providers that some men usually call to ask questions. It is however interesting that among the questions that are usually asked are questions about intimacy during pregnancy and when it should begin after childbirth. Throughout my observations at the facility, healthcare providers continuously discussed the issue of intimacy during and after childbirth. The advice was that women should not deny their partners intimacy during pregnancy and should go on family planning six weeks after childbirth, except, in cases of caesarean sections. Consequently, women could have intimacy with their partners and at the same time avoid unwanted pregnancy, which could be harmful to the health of mothers and children.

7.2.0 Men's experiences of labour and childbirth

Though most men are unable to attend antenatal clinic, they take their partners to the hospital for delivery. Most hospitals in Ghana, including the Police Hospital where this study was conducted, do not permit men in the delivery room. Men have to wait outside because of inadequate space in the labour and delivery rooms.

7.2.1 Expectations of male partners during labour and delivery

Women would like their partners to be permitted in the delivery room to share the experience, for protection and comfort. For example, a woman who had a stillbirth during her first delivery had this to share:

When I lost my baby during my first pregnancy, I was very depressed. At that time, I felt lonely and needed someone to console me but there was no one there and I cried alone. At least if my husband was allowed inside, he would have consoled me. I

really wish that our men will be present to motivate us. Even during contraction, they can hold you and support you (Woman, pregnancy school, 25th August 2012, Accra).

This quote shows that women would like to have their partners' support in the labour room, to share the experience together, whether good or bad. Most women, however, said that the most important reason is for men to see the pain they (women) go through to increase men's respect for women as well as reduce men's desires for large families. A woman shared her views during a discussion:

Having men in the labour room will be better off. When you are pregnant some of the men think it is just a big stomach which will surely come down. Preferably they should be in the room with you to see what you are going through. Some of them in less than two years, they want you to become pregnant again. Especially the men who talk to women anyhow, they should come and see and then they will learn to respect women. If this is the kind of pain you are going through before you are bringing one, then they will say we should wait a while before the second one comes. (Woman, FGD 3, 25th July 2012, Accra).

Another woman said:

It is a very good idea to have men in the labour room. There is a friend who was with his wife in the room. She had his baby at a private clinic and he was there with her. After that he said, "I don't think I can make my wife pregnant again" (Woman, pregnancy school, 25th August 2012, Accra).

Similarly, a pregnancy school facilitator shared her views on the need to have men in the labour ward:

For the two children I had I wished my husband was with me. But it looks like our maternity and labour wards were not built to accommodate that. But if it is possible to do it, that would be very good. It is important because the few men I know who have witnessed the birth of their children have changed their attitudes towards their wives. They respect them and are more supportive with childcare (Pregnancy school facilitator, 16th August 2012, Accra).

Similar ideas have been expressed by women in Guatemala and Nepal (Carter, 2002a; Mullany, 2006). Women in Mullany's (2006) study said men should be permitted in the delivery rooms for support and to witness women's pain, hoping that it would generate more respect and reduce men's desire for large families. A public health nurse also explained men's presence in delivery rooms in relation to the attitudes of healthcare providers at the labour wards and the general conditions of the ward.

Terrible things are happening in our labour wards. You go there and it is all noisy and clumsy. Midwives just ask women to take off their clothes and lie down. They do not give women the opportunity to express themselves about how they feel or ask questions about why they should do this or that. They just ask them to shut up and obey instructions. Women are taken for caesarean sections without them knowing why they need it. They and their partners are not informed about what is happening during labour and afterwards. They just have to obey. Why can't a woman have a caesarean if she wants to? Why should every woman be forced to go through labour? If she cannot have a normal delivery she should have an option. But they (nurse-midwives and doctors) decide and they just expect women to obey. If the men are with them all the way, even in the delivery room, they will be able to witness issues for themselves and ask questions on behalf of their partners (Public Health Nurse, 23rd August 2012, Accra).

The concern of this nurse is related to those expressed by women as to why men should accompany them to the antenatal and postnatal clinic because they will be treated better since men are more respected in the society than women. However, some women also said that some men are fearful and cannot behold the sight of blood and their partners suffering and wailing in pain. Thus, even though it should be allowed, men could be given an option to choose. According to a woman:

My husband is fearful. When I was sick, he kept asking are you ok, should I get you water, he could not sleep. Because of this if he stands there, by the time you will finish giving birth, he will also have given birth (Woman, FGD 3, 25th July 2012, Accra).

Healthcare providers also think similarly. According to them, men are permitted when their partners happen to be the only one in the labour ward. However, some men do collapse in the process. For example:

One of our clients, while waiting outside, hearing his wife scream and shout made him collapse and by the time his wife was delivered, he was on admission at the hospital. His wife was even discharged before he was discharged. That was waiting outside; you can imagine how it would have been in the delivery room (Community Nutritionist, 23rd July 2012, Accra).

This shows that men's presence during labour may not always be positive on the process as indicated in some literature (Dellman, 2004). For instance, if this man exemplified above was permitted in the labour room and he collapsed during the process in the presence of his wife, it could have had negative consequences on the process. However, it could also be argued that this man collapsed because he was not present to see what was happening and hearing his partner wail made him fearful. Perhaps, if he was part of the process and witnessed events as they unfolded, he would not have collapsed. Nevertheless, healthcare providers' expressions about men's presence also show how notions of masculinity are constructed in pregnancy and labour. Men are sometimes constructed as fearful, which results in relegating them to the periphery. Interviews with men however, indicate that some men see themselves as confident and stoic to contain the labour process as the next section will show.

7.2.2 Men's accounts and expectations of labour and delivery

Men interviewed in this study narrated their confidence and support during labour and how they would love to be part of the process. For example, David shared his experience and how it made him delay the next pregnancy:

I brought her (wife) to the hospital. And I was in the room with her. Then the nurses asked me to excuse them. She was crying and screaming and I wanted to cry but I am a man so I just consoled myself and refused to cry..... within ten minutes, she had delivered.... I could have stood there, after all she is my wife and I have to be there to make sure everything goes well.....If we (men) are given the opportunity, from

my perspective we will be able to stand there. She was crying and I heard her screaming so when we came home, I was laughing at her. She said it was very, very painful and she said she will not give birth again and I told her, "you are lying.", but after that I wanted her to be free for some time and recover from the pain. Our son is five years and I am now expecting the second one. I made her go on family planning before this pregnancy because I did not want the children to be too close and worrying her.

David's narrative expresses his confidence and ability to suppress his emotions. He also believes he could have been there to be sure that everything was alright even though he had no medical competence. This indicates some sort of marginalization and regret because he was not part of the process. Similarly, Enoch expressed a bit of disappointment for not being there:

I was at the labour ward. I was about a metre away from where she was giving birth. I was at the entrance while she was inside so I could spot her from there. I would have loved to be there. At Nyaho hospital and North Ridge hospital you are allowed to be there. But here, I was only at the entrance praying and giving her my moral support (Enoch, 19th July 2012, Accra).

Though Enoch was not in the room, he felt he gave his support by staying at the entrance and praying. Clement's support was also by praying and keeping wake at night. He said:

When she was due to deliver, I brought her. When we (Clement and mother-in-law) brought her, it was about 9pm, and at about 1am the doctor asked us to go home. I could not sleep. I kept thinking and praying, hoping that it will be fine. By 4pm we were informed that she had given birth and when I came and carried my baby in my arms, I was so glad it had happened.....I could have stayed with her if allowed to so that we could go through it together (Clement, 2nd August 2012, Accra).

Some first time expectant fathers interviewed were also hoping to be there. According to Simon:

You see it is not allowed here but if it is allowed, why not. I will be there with her. But it will not be easy at all. You see after I found that she was pregnant, I became very happy and excited that I am going to be a father even though it was unexpected. Now even when I leave her alone at home and go to work I am always thinking about her and the baby. I am thinking of how the baby will look like, like me or like her. So I would like to be there but the way I feel about my wife, I may cry if she is in pain because women have a lot of pain when they are in labour...and in this time of maternal mortality.....hmm am always thinking and praying about that time for her....I am the man and the one who has to comfort her so I do not have to look worried or cry else she will also think and it will affect the baby...but I know God is in control. This is why I always want to be beside her and even come to the clinic with her and hear the instructions they give so we can follow it well (Simon, 17th July 2012, Accra).

Simon's narrative expressed his feelings about the pregnancy as well as his expectation during labour. He stated that he could possibly cry if he attends the labour session due to the anticipated pain of labour. However, he tries to keep his fear to himself because doing so could make his partner anxious and he does not want that to happen. Another man also expressed his desire to share the experience with his wife:

Being in the delivery room with my wife is one thing I am going to insist on, no matter what. I have to be there so that we can share it together. We have watched a movie of labour and delivery at the pregnancy school and I have seen what women go through so I want to be there. And after watching that movie, I do not think I want to have a second child (Man, pregnancy school, 25th August 2012, Accra).

Though his wife has not delivered yet, he is considering not having more children because of the pain he is anticipating she will experience. These accounts of men also illustrate that it is not always the case that men are fearful as some healthcare providers claimed. As indicated by David and some women, men's experience of labour could lead to positive outcomes for maternal healthcare such as birth spacing and fertility reduction. The narratives also highlight the expanding expectations of fatherhood, that providing for the family is no more enough to claim relatedness and

fatherhood. However, similar to Middleton's (2000) discussion of how Karembola men become mothers; some men in Ghana expect to participate in antenatal and postnatal clinics, labour and delivery sessions as well as change some habits to show fatherhood and relatedness.

7.3 Engaging dominant gender ideals at antenatal, delivery and postnatal clinics

Gender ideals about provision and decision-making for the household and the gendered use of space can be seen as constantly engaged by men, women and healthcare providers in this chapter. First, in mentioning why men should attend antenatal and postnatal clinics, reference is made to men's performance of tasks such as providing for the family. This role is one of the ways of asserting masculinity in the Ghanaian society (Miescher, 2003; 2005; Agorde, 2006; See also Dolan & Coe, 2011). Reference is also made to another dominant ideal that men are the decision-makers and sometimes reluctant to take instructions from women. In addition, women's desire to have their partners accompany them to the clinic in order to be treated well highlights the expectation that men are more respected than women. Consequently, women draw on men to acquire some respect. In this regard, the process of men increasingly attending antenatal and postnatal clinics, which could promote the equal participation of men and women in maternal healthcare, could also lead to the reproduction of hegemonic masculinity and emphasized femininity (Connell, 1987; 1995).

Men's presence at the clinic is also underlined by gender ideals stemming from the definition of the clinic as women's space. Some studies have indicated that men in spaces traditionally defined as feminine have the fear of being feminized by coming into contact with women or being stigmatized by society as effeminate (Lupton, 2000, p.38). This could explain why men are sometimes reluctant to participate in antenatal and postnatal clinics. However, these leading ideals of masculinity can also be seen as challenged and resisted by some men and women. One example is Simon, a key informant in this study who attended the antenatal clinic with his partner and participated in the procedures at the clinic. Another example is the man who attended

the postnatal clinic and participated in the discussion with the nursing mothers. The mothers and nurse-midwives laughed at Simon that he was out of place and applauded the man for participating in the discussion. Even though Simon and this man can be seen to be resisting the dominant ideal, the women and nurse-midwife responded in a way that could be described as complicit with hegemonic masculinity. In the framework of Connell (1987; 1995), this could also be referred to as emphasized femininity.

However, applauding men who attend antenatal and postnatal clinics could also be a way of opening up for resistance and change of the perception that these clinics are feminine spaces. This is because applauding men could make men feel comfortable in these spaces and encourage other men to participate. After sometime, it may become common for men to participate, thereby, possibly changing the perception that the antenatal and postnatal clinics are for women. Another possible way of challenging dominant gender ideals can be identified in women's concern that men's participation in delivery could lead to equality between couples in performing household and reproductive responsibilities. According to some women, there would be equality since men would understand women's desire for smaller families; they would be more involved in subsequent pregnancies and childcare; and perform housework. The idea of equality expressed by these women is similar to the plans of actions of the ICPD 1994, which encourages harmonious partnership in the sharing of household and reproductive duties between couples (UN, 1995).

Thus, accounts in this chapter show that some men and women are being resistant, complicit and cooperative at the same time (Connell, 1987; 1995). These engagements with dominant gender ideals could nonetheless expand and change the expectations of fathers with time. Fathers, in addition to providing, would be expected to attend antenatal and postnatal clinics as well as participate in delivery. Such change could illustrate how a subordinate model of masculinity, associated with femininity, could influence a dominant model (Connell, 1995; Demetriou, 2001; Connell & Messerschmidt, 2005). However, this influence may not change dominant gender ideals around reproduction but could reconfigure hegemony (Connell, 1995;

Demetriou, 2001). This is because men's participation in these activities defined as feminine may not be seen by men as an equal responsibility of men in maternal healthcare. Rather, it may be seen as a way of performing fatherhood and asserting masculinity.

7.4 Chapter summary

This chapter has discussed the significance of men's presence and support at the antenatal clinic, delivery room and postnatal clinics. It has also examined why men are most often unable to attend these clinics even though women and healthcare providers see it as important. Moreover, the chapter has explored both men and women's desire to share the experience of childbirth through men's presence and support in the delivery room. Discussions in the chapter reveal that even though men's presence in these spaces dominated by women could promote the participation of men in maternal healthcare, hegemonic masculine ideals could also be reproduced. This is because women and healthcare providers draw upon and reinforce dominant images of men as providers, decision-makers and more respected than women.

In the next chapter, the healthcare system is explored to examine its role in shaping men's participation in pregnancy and childbirth. Whereas this chapter and the previous chapter have mainly focused on gender relations at the individual and social levels, the next chapter focuses more strongly on the structural level, by focusing on healthcare programmes and policies. It discusses the extent to which dominant gender practices are altered or reproduced by the healthcare system in its attempt to involve men in maternal healthcare.

CHAPTER 8: HEALTH PROGRAMMES AND POLICIES INVOLVING MEN IN MATERNAL HEALTHCARE

8.0 Introduction

The two previous chapters have discussed men's performance of housework and participation in antenatal and postnatal clinics. Some of the findings indicate that gender roles in the household become more fluid during pregnancy, childbirth and the postpartum period. Some men also participate in antenatal and postnatal clinics and desire to be part of delivery. This chapter focuses on the medical system and explores how it contributes to drawing men into the domain of pregnancy and childbirth.

In recent years, the international health community has called for the involvement of men in maternal healthcare (UNFPA, 2004; 2007; 2010; 2011). In Ghana, different measures, including serving women who bring their partners to antenatal and postnatal clinic first, rewarding men in monetary terms for attending antenatal clinic and organizing pregnancy school for expectant couples, are on-going in the attempt to involve men. In the context of this study, two of these measures; serving women who attend clinic with their partners first, and pregnancy schools, are undertaken as measures to involve men. This chapter discusses how these programmes affect men's participation in maternal healthcare, notions of fatherhood and the extended kin relations during pregnancy and childbirth. It ends by examining how these programmes build on, change or reproduce dominant notions of gender practices around maternal healthcare.

8.1.0 Pregnancy school

On 22nd January 2000, a group of eight expectant mothers under the leadership of a public health nurse at the Ghana Police Hospital in Accra started a pregnancy school. The public health nurse joined the maternal and child health unit in 1998. Part of her responsibility was educating expectant and nursing mothers at the antenatal and postnatal clinic on nutrition, hygiene and other health needs during pregnancy and after childbirth. In the process, she realised that the time spent on these issues during the clinic hours was limited. Very often the nurse-midwives, waiting to examine

expectant mothers, would complain that she was delaying the pregnant women and slowing down procedures at the clinic. On the other hand, the public health nurse felt the expectant and postpartum mothers needed to know more. Consequently, she thought of organizing extra lessons for mothers to get them more informed. However, she did not implement her idea until an incident occurred in 1999. She narrated:

I saw this woman in the postnatal clinic, when she entered the room the whole atmosphere changed with a bad smell. So I asked and she said she could also smell something but she did not know what was wrong. So I asked her to lie down for me to examine her, which is a routine with any woman who has undergone episiotomy¹⁰. She opened her thighs and I saw this blackish thing in her vagina. So I asked if she was aware of any blackish thing inside her vagina. And she said yes, she was feeling it but she thought it was normal since she was given an episiotomy. Then I said no, it is a sanitary pad that had been stuck in there. I asked whether she was not told to remove it and she said she could not remember. The pad had been there for three weeks. It was rotten and caused her vagina to rot. So I quickly referred her to the gynaecologist and she was rushed to the theatre, the pad was removed and her vagina and womb were cleaned up and she was given some antibiotics. It was then that I said, we cannot wait any longer, we have to act now. (Public Health Nurse, 23th August 2012, Accra).

Therefore, in January 2000 she asked some of the expectant mothers whether they would be interested in receiving extra lessons on Saturday mornings, at most twice in a month. Eight women showed interest and agreed to participate. This is how the pregnancy school at the Ghana Police Hospital, Accra started. The pregnancy school is different from the antenatal and postnatal clinic. First of all, pregnancy school occurs on every other Saturday and all pregnant mothers can decide to attend without appointment, whereas women have a monthly appointment to attend antenatal or postnatal clinic. No physical examination is conducted on women, which is, in contrast, a routine during the antenatal and postnatal visits. Rather, women are engaged in discussions using a teaching manual prepared by the public health nurse

¹⁰ “Episiotomy is a surgical incision used to enlarge the vaginal opening to help deliver a baby” (www.americanpregnancy.org/abornbirth/episiotomy.html).

with the assistance of other healthcare professionals. The teaching manual has a programme outline which covers different aspects of pregnancy such as nutrition, the stages of labour, breastfeeding, episiotomy and hygiene during pregnancy and after childbirth, the role of men, among others. At the antenatal and postnatal clinics, this kind of information is given briefly by nurses, nutritionists or nurse-midwives without the assistance of a teaching manual.

From 2001 to 2011, the school could record about 100 pregnant women with different social backgrounds per class. However, 2012 witnessed a decrease due to a registration fee of ten Ghana Cedis (\$5) charged to provide for the materials and other expenditures of the school. Two visits to the school showed that about thirty women and a maximum of two men with different social backgrounds participated in a class. They included accountants, beauticians, marketing managers, caterers, hairdressers, seamstresses and petty traders. The classes are conducted in Twi (one of the local Ghanaian languages widely spoken in Accra) and all women are given handouts with pictorial explanations. Most of the participants in the classes were first time expectant parents, though a few were second and multiple times parents.

Different tutors or facilitators (including; a social psychologist, nurse-midwives, nutritionist and public health practitioners) are invited to speak according to the topic for discussion. Sometimes participants can become tutors/facilitators upon receiving some form of training from the organizers of the school. That was the case of Cynthia, a social psychologist. According to Cynthia:

When I was pregnant with my second child, I came to the Police hospital for antenatal care and the organizer of the school came to make an announcement and after the announcement, I followed her and wanted to know more about the programme. I quickly agreed to join the class because I saw it as opportunity to be with people. Because of my level of interest when I started, she asked me to share my experience with the class. She also gave me books and materials to equip me regarding the issues so that I can help as a facilitator. So I was a student as well as a facilitator. That was in 2002. Since then, I have been part of the programme as a voluntary facilitator (Pregnancy School Facilitator, 3rd August 2012, Accra).

Facilitators are aided by a teaching manual which covers different aspects of pregnancy and childbirth. Other materials such as dolls and handouts are given out to participants to practise and read. For instance, during an observation at one of the classes, dolls were given to all participants, including men, to demonstrate the best position of babies during breastfeeding and bathing. Handouts on breastfeeding with pictures were given to all participants to read and for those who could not read, they looked at the pictorial demonstrations. The facilitator emphasized exclusive breastfeeding for six months, a directive given to all mothers by the Ghana Health Service. She also explained how working mothers could combine breastfeeding with their work schedules and the types of food to be introduced as supplements when the baby is six months old and. She also stressed that men could participate in breastfeeding by helping their partners to carry and pat the baby at the back while the mother rests after breastfeeding. Finally, she emphasized how to deal with extended family if they are called to help. She encouraged parents to set the rules for kin members and explain to kin members the importance of following those rules.

8.1.1 Men at pregnancy classes

The school started with women only, and the point at which it started to involve men has remained unclear. However, as emphasized by two facilitators interviewed, the school had an agenda of involving men because “in the business of producing children both the man and woman are involved.” Women were therefore encouraged to bring their partners. However, most often, as occurred at the antenatal and postnatal clinics too, women gave excuses for why their partners could not join. The excuses included the following; “my husband is gone to work; my husband says it is only for women; and my husband says he does not feel comfortable sitting among women” (Public Health Nurse, 23rd August 2012, Accra). Some men accompanied their partners but refused to participate in the class. A couple had this to share:

The woman started: *At first it was not easy for him at all. He will wait in the car while the class takes place.*

The man continued: *It was not easy for me at first, sitting alone in the midst of women. But now I am ok, especially when I am not the only man. Sometimes other men also come; you will see three or four* (Couple, 3rd August 2012, Accra).

A woman also narrated her husband's attitude at the school:

My husband has never attended antenatal clinic with me because of his work. But he came for the pregnancy school since it is on a Saturday. However, because of the women, he sat somewhere on the compound and refused to come close to the meeting. He said he was shy to be the only man sitting among women. (Woman, FGD 2, 24th August 2012, Accra).

These two examples, which reflect similar accounts of other participants, revealed that whereas work was not a strong reason for men's inability to participate in the pregnancy school, shyness was. Shyness of men at pregnancy school is similar to shyness at the antenatal and postnatal clinic explained in the previous chapter. First, men were sometimes uncomfortable finding themselves in a minority in a space dominated by women. Some men also claimed to be shy listening to discussions concerning reproductive health. Others were also afraid of social stigma.

Some studies have suggested that men's participation in maternal health education programmes could be more effective if conducted in different groups like women's group, men's group, singles group and couples group (Mullany, 2006; Leavitt, 2009). This was practised in the USA in the 1940s and 1950s when men were grouped into a male group and their class led by a male physician, while women were in a women's group with their class led by a female nurse-midwife (Leavitt, 2009). According to Leavitt (2009), this was an effective way of involving men in prenatal classes in the USA during the period. Similarly in Ghana, in 2010, the pregnancy school at the Police Hospital adopted a strategy of organizing separate classes for expectant fathers with a male facilitator. This class took place during the same time that the women's class occurred so that men who accompanied their partners could participate. This class mainly discussed issues concerning men in pregnancy. According to the head of the school, this was successful and it encouraged more

expectant fathers to attend and participate. Sometimes the two classes, of men and women, were merged.

However, too soon, the men's class collapsed because there were no male facilitators to engage male partners. As a result, men had to join the women's group and subsequently, the number of men attending the class began to decrease. Men's numbers decreasing could be related to shyness as indicated above. Moreover, it is also likely that these joint lessons concentrated more on women in pregnancy than men in pregnancy. In this case some men could feel they were a minority in a space and discussion dominated by women. Henceforth, at most four men showed up per class. Whenever a man showed up while the class was on-going, the facilitator leading the discussion would pause and ask him to introduce himself and the whole class would clap for him. Women who showed up while the class was on-going were not applauded. Applauding men who show up could be the school's way of helping these men deal with the issue of shyness. Even though these men can be seen as resisting the dominant masculine ideal by showing up, applauding them re-endorses their masculinity and emphasizes femininity in the framework of Connell (1987; 1995).

The school used men's role as head and protectors of the family to explain to men that pregnancy is not only for women. As emphasized by the leader of the school, "it is your blood that is growing inside the woman, so who do you expect to take care of your blood" (Public Health Nurse, 23rd August 2012). Some of the things mentioned that a man can do to take care of "his blood" includes fetching water for his partner during pregnancy, shopping, washing and ensuring that she rests as advised by nurse-midwives; reminding her to take iron supplements, eat well and exercise and also massaging her. The mention of blood by the public health nurse relates to notions of kinship and fatherhood that are widely accepted in Africa and Ghana. The activities that men could perform to take care of their blood relates to Middleton's discussion of the couvade among the Karembola where men fetched water and firewood and cooked during the postpartum period in order to prove paternity and relatedness (2000, p.117). This notion also relates to Richter and Morrell's (2006) discussion of fatherhood; the ability to impregnate a woman and accepting and performing the role of a father,

notions which are also relevant in the construction of masculinities in Africa. In this regard, the school could be seen as drawing on a hegemonic notion of masculinity (Connell, 1995). This idea of taking care of blood could also explain fathers' protection of pregnant mothers mentioned by participants in the two previous chapters.

The school also explained to men and women that men's involvement promotes family togetherness. For example during an observation in a class, men and women were taught about breastfeeding and how men could help. After breastfeeding, the father could carry the baby and pat him/her at the back until she/he sleeps. Men can also help in changing diapers, buying and packing items for delivery, and more importantly setting rules for the extended family members with regards to how to care for mother and child.

Some of the lessons at the pregnancy school could have been influenced by international health community like the UNFPA and international conferences like the ICPD 1994. The idea of family togetherness for instance is related to the ICPD 1994 plan of action regarding male participation in all aspects of family responsibilities such as childcare, housework, family planning among others, in order to promote gender equality (UN, 1995, p. 27). In addition, some of the activities of the school are similar to campaigns of the UNFPA on involving men in maternal healthcare. The UNFPA supports activities that would encourage men to participate in maternal healthcare in countries including Brazil, Thailand, Indonesia, Nigeria, and Zimbabwe among others (UNFPA, 2007, *It takes two*). For instance, a story from Thailand indicates how parental classes improved communication between partners and thought men and women how to bath their babies (UNFPA, 2007, *A father's magic touch*). Such lessons had helped some fathers to care for their newborns (UNFPA, 2007, *A father's magic touch*). Similar narratives were shared by participants in Accra with regards to the pregnancy school as the next section will show.

8.1.2 Significance of the pregnancy school

Lessons at the school can be seen as impacting the attitudes of expectant men and women. According to the leader of the school, "the pregnancy school is empowering, and couples team up with their partners and support each other without

the support of mothers and extended family interferences”. As discussed in the two previous chapters, some extended family members could interfere during pregnancy and ill-advice mothers. However, when both men and women are aware of medical advice, the man sets the rules even before an extended family member is called upon to assist. Breastfeeding, making postpartum mothers sit on hot water and using a warm towel to massage the heads of babies are usually controversial between mothers and kin. However, discussion with women at a pregnancy class revealed that when men themselves hear that some of these practices are not good, they discourage the women as well as any other person who assists. Thus, this practice of men setting the rules could reduce the interference of extended family during pregnancy and childbirth. However, men setting the rules also emphasize a hegemonic masculine ideal that men are the major decision-makers in the home and therefore carry more authority than women.

Apart from setting rules, some women said that lessons from the school have equipped them to take care of themselves without the assistance of kin. For example a first time expectant mother shared this in a focus group:

Perhaps my mother will come but if she does not, because of the pregnancy school which takes place here and in which I participate, I will be able to take care of myself and the child, bath and do everything on my own without any assistance. They have taught us everything; how to bath, breastfeed, they even have dolls which they use to give us examples... They even brought a midwife to teach us how to manage labour. It is very helpful (Woman, FGD, 2, 24th July 2012, Accra).

This example speaks to the issue of kin relations during pregnancy and childbirth and confirms examples in other studies and the previous chapters that women need the support of older female relatives because they lack experience in maternal healthcare (Jansen, 2006). This woman quoted above could be referred to as inexperienced. However, from her narrative, the lessons could help deal with the problem of inexperience and reduce kin support during pregnancy and childbirth to some extent. Other participants indicated that the school has increased their knowledge on how men could support, which they communicate with their partners. Some

participants indicated that lessons at the school have changed their partners' attitudes, and strengthened communication between them and their partners:

When I started coming to the school, my husband would drop me off and return home. Sometimes he would wait outside but he would not join saying that he is not pregnant. I did not see anything wrong with what he was saying until we had a lesson on how men could also support. So when I returned home that day, I told him, ei you, you always drop me off at the school but you never bother to ask what they tell us. How will you know if they are not telling us any bad thing if you do not ask? So he said well, it never occurred to him. I gave him some of the handouts which he read and ever since, whenever I return home, he would ask, what did you learn today and he will even take my notes and read. Similarly, when I attend antenatal too, he will ask me questions and sometimes even tell me to ask the midwives specific questions when I go (Woman, Pregnancy school, 25th August 2012, Accra).

A man participating in the programme also shared similar views:

My wife started attending the class and she told me men could also attend. So I made it a point to come with her whenever I was less busy on Saturdays. Men who attend are usually engaged in the discussion. It is an educative programme, we have learnt what to do as fathers to support, like patting the baby after breastfeeding, sometimes putting the baby to sleep and letting the mother rest at night etc. Even now, I am not allowing her to do too much at home like standing and cooking for long hours, shopping etc. But my wife is stubborn and she likes to do everything telling me that pregnancy is not an illness. So I remind her of what we learn at the school and sometimes, she listens. We are getting ready for the baby and I hope other men will come for the classes (Man, pregnancy school, 25th August 2012, Accra).

Some of these examples show that the school is promoting communication, partnership and equal participation of men and women in family and household responsibilities as emphasized by the ICPD 1994 (UN, 1995, p.27). This could contribute to changes in gender division of household labour, thereby, promoting equality between men and women as highlighted by the ICPD 1994 (UN, 1995).

8.2 Hospital policy: come with your partner and you will be served first

Apart from the pregnancy school which is making some efforts to reach out to men to actively participate in maternal healthcare, the Police Hospital also has an arrangement of attending to women who attend antenatal and postnatal clinic with their partner first. This is independent of whether they arrive earlier or later than other women. Interviews with healthcare providers at the hospital revealed that this is a way of motivating men to attend the clinics with their partners, which could produce positive health outcomes.

However, another reason for serving women who attend clinics with their partners first could be related to the work schedule of most men in Ghana. It has been indicated in other studies that men's employment situations also prevent them from participating in antenatal and postnatal clinics (Carter 2002a; UNFPA, 2004; 2007; 2010; 2011). In Ghana for instance, whereas women could seek permission from their workplaces to attend antenatal and postnatal clinics, men do not have such opportunities. This is because, generally, men in Ghana are not given paternity leave. Participants and informants showed mixed feelings towards paternity leave. The majority of participants in the study were self-employed, and not working in the public sector. This group of participants said paternity leave would benefit men who work in the public sector more than self-employed fathers. If self-employed fathers gave themselves paternity leave, it would reduce their income, combined with an expected increased expenditure during pregnancy and childbirth.

Some participants who work in the public sector said they would like to have paternity leave. For instance, in a conversation with two medical practitioners, one stated that men would attend the antenatal and postnatal clinic if they would be given paternity leave with pay. Nevertheless, most women said that men may not use paternity leave to support mothers during pregnancy or childbirth. This scepticism about paternity leave could be summarized in a story shared by Cynthia, a pregnancy school facilitator:

I know this couple who had a baby. The man was so excited about the birth of the child so the company decided to give him leave for some time. They gave him about 3 or 4 weeks. You know (laughing) for the four weeks he never spent a single day with his wife and the baby at home. He was doing his business trying to get clients etc. For him it was an extension to do his business. So for paternity leave, I am not sure we as a people, nation or society are ready for that. There are some men who may spend that time with the baby but I am very sure the majority of men will not. They will love to have the free time but will not spend it with mother and child (Facilitator, 3rd August 2012, Accra).

Moreover, paternity leave could create classes among men in terms of who would be able to perform their responsibilities as fathers, and who would not. As some participants have indicated, paternity leave would benefit men in the public sector more than those who are self-employed. As a result, self-employed fathers could be subordinated to fathers who work for the public sector.

Thus, in an attempt to help men participate in the antenatal and postnatal clinics with minimal interruption in their work schedule, the hospital serves women who attend the clinics with their partners first before other women who are not accompanied by their partners. Despite the existence of this arrangement, as discussed in the previous chapter, most fathers do not attend antenatal and postnatal clinic because some people define it as a space dominated by women and inconvenient in relation to their work schedule.

It is possible, though, that some men who attend the antenatal clinic with their partners do so because of this policy. For example, according to Simon:

So far we (men) are treated well, and when you come with your wife, they see to you early which is good for the woman too so you can both go home early. When you ask questions too, they respond to you well so it is good. You know people usually say that the nurses are rude and other things, but I have not experienced anything like that (Simon, 17th July 2012, Accra).

Simon showed a lot of concern for the health of his partner. The mention of seeing to his partner early when he accompanies her to the clinic could be a motivating reason for Simon's assistance at the clinic. Also, his mention of nurse-midwives responding to his questions confirms some women's concern that men's participation in antenatal and postnatal clinics could enhance communication between women and healthcare providers. Most participants in the study also agreed that it is a good policy. Some women said that because of this arrangement, they make an effort to bring their partners.

However, the policy does not consider single mothers as well as mothers who attend antenatal and postnatal clinics alone. As indicated in some studies, unwanted pregnancies could sometimes produce unhealthy relationship between partners (Carter, 2002b). Thus, men who are not expecting to be fathers are less likely to be involved in maternal healthcare. Accordingly, mothers in relationships in which their partners are not expecting to be fathers, may not be able to attend clinics with their partners. Therefore, they will not have the opportunity of quick attendance. Hunt and De Mesquita (2010) have indicated that in order to improve maternal health and reduce maternal mortality, health services should be accessible and non-discriminatory. Policies, laws and practices should be structured in ways that will not create gender inequalities (Hunt & De Mesquita, 2010, p. 6). However, in the case of this policy, inequalities could be created among women and hinder some women's access to maternal healthcare.

8.3 Structural alteration and reproduction of hegemonic masculinity

As indicated by Connell, "hegemony is likely to be established only if there is some correspondence between cultural ideal and institutional power, collective if not individual" (1995, p. 77). In this chapter, there seems to be an interaction between cultural ideals and the pregnancy school in this case. Lindsay and Miescher have also emphasized that the study of the configuration of masculinities should explore institutions that shape dominant gender ideals, how they shape these ideals and the context in which these ideals are shaped (2003, p.7). With regards to men's

participation in maternal healthcare in Accra, the pregnancy school can be seen as altering and reproducing dominant gender ideals. The school is drawing on cultural ideals such as that of men as the providers, decision-makers and protectors of the family, in order to challenge another ideal that defines pregnancy and childbirth as spheres dominated by women. In so doing, the reasons for men's participation in pregnancy and childbirth, according to the school, is because of men's roles as providers, protectors and decision-makers in the family. In this light, subordinate model of masculinity, which define pregnancy and childbirth as a preserve for women could merge with dominant models which describe men as the providers, decision-makers and protectors of the family (Demetriou, 2001; Connell & Messerschmidt, 2005). Consequently, men's attitude could be changed in terms of their participation in pregnancy, childbirth and postpartum care. However, this may occur without changing gender relations but create a more "stable belief of the superiority of men to women" (Lusher & Robins, 2009, p.395; See also Bourdieu, 2001; Demetriou, 2001).

It could also be argued that the arrangement of serving women who attend antenatal and postnatal clinics with their partners first, attaches a lot of significance to the male partner in accessing maternal healthcare. This could neglect and subordinate some women. Related to Connell's idea of emphasized femininity, the hospital in this case can be seen as complying with the subordination of women and pursuing the interests of men (1987, p.183). In addition, as discussed in the previous chapter, women who attend the clinic with their partners feel more respected. Thus, mothers draw on the respect given to men to acquire some respect themselves. However, single mothers who do not have partners and married mothers whose husband's are unable to accompany them to the clinic are denied the opportunity of this "respect".

In this light, apart from creating differences between men and women by re-affirming the dominance of men, the hospital can also be seen as creating a difference among women. Women, who are unable to attend the clinic with their partners, as well as single mothers, are subordinated to women who are able to do so. Thus, healthcare practices and programmes could also reproduce hegemonic masculinity in the process of drawing men into the domain of pregnancy and childbirth. Moreover, instead of

bridging the gender gap in reproductive responsibilities, new forms of inequalities between women and men and among women could be created.

8.4 Chapter summary

This chapter has discussed two main programmes ongoing at the Ghana Police Hospital, Accra, to involve men in maternal healthcare. Pregnancy classes organized for couples has been discussed as relevant in the sense that it educates couples to set rules for extended family members and enabling couples to team together to discuss and share the experiences of pregnancy and childbirth. However, the school could also reproduce dominant gender ideals by drawing men into pregnancy and childbirth using their roles as providers, protectors and decision-makers. In addition, the arrangement of attending to women who attend clinics with their partners first has been identified as a starting point to promote men's participation in antenatal and postnatal clinics. However, this arrangement could also reproduce dominant gender ideals as well as create inequalities among women which could hinder some women's access to maternal healthcare.

CHAPTER 9: CONCLUDING COMMENTS

This thesis set out to answer three main questions: In what ways do gender ideals shape men's involvement and contribution to maternal healthcare? In what ways do household arrangements, women's employment situation and kin relations shape men's contribution to maternal healthcare? And in what ways do healthcare practices accommodate for or hinder men's contribution towards maternal healthcare? Three main themes emerged from the data with which these questions are answered. The first theme relates to men's performance of housework in general, and especially during pregnancy, childbirth and the postpartum period. The second theme relates to men's participation in antenatal and postnatal clinics as well as delivery. The last theme relates to two healthcare programmes: serving women who attend antenatal and postnatal clinics with their partners first whether they come earlier or later than women who are not accompanied by their partners; and organizing pregnancy lessons for pregnant couples.

In the household, the data shows that men share housework with women, especially during pregnancy and after childbirth. Men perform tasks such as cooking, washing, cleaning and shopping. Couples who live in their private apartments are more likely to share housework than those who live in compound houses. Women's work situation also influences their partners' performance of housework such that when both partners work outside the home, they are also likely to share housework. Finally, kin support for maternal healthcare and domestic work is dwindling, making men perform housework more often. Based on these findings, I make the point that dwindling kin relations and women's work situation are altering dominant gender roles during pregnancy, childbirth and the postpartum period. Thus, some men perform household duties and share the burdens related to pregnancy and childbirth with their partners. However, social perception about gender roles in the household sometimes prevents men from performing household chores. In dealing with the social perceptions about men's performance of housework, men and women share housework in a way that men perform chores which are indoors while women perform chores which are outdoors. This practice of men and women in this case could be

described as complicit because they are not openly disregarding social expectations of dominant gender norms (Connell, 1995).

At the clinic, women indicate that it is important for men to accompany them for financial and social support, to remind and correct them with regards to important health information, for respect and for protection. Women want men to participate during labour and delivery for emotional support, respect and to reduce men's desires for large families. But men are unable to attend antenatal and postnatal clinics because of their work schedule and shyness of staying in a space dominated by women. In relation to delivery, all men who participated in the study are willing to participate and share labour and birthing experiences with their partners. However, lack of space at the labour ward often prevents men from doing so. Based on these findings, I make the point that men and women see the need and significance to share the experience of pregnancy and childbirth in ways which could promote equal sharing of the burdens related to reproduction. However, in an attempt to encourage men to participate in antenatal, delivery and postnatal clinics, women and healthcare providers appeal to men using their roles as providers, decision-makers and protectors of their families. In so doing, dominant gender ideals could be reproduced (Connell, 1995; Demetriou, 2001). This is because men may participate in antenatal, delivery and postnatal clinics not as a shared responsibility but as another way of asserting their masculinity and dominance over women.

The police hospital has a policy of serving women who attend the clinic with their partners first. This policy could encourage men to attend antenatal and postnatal clinics. However, it could also reproduce male superiority and female subordination and create inequalities among women in accessing maternal healthcare (Hunt & De Mesquita, 2010). The hospital also organizes pregnancy classes for couples to teach them about the challenges of pregnancy on topics including nutrition, breastfeeding, managing labour and dealing with extended family members who support with maternal healthcare. The programme reaches out to men using their roles as providers, decision-makers and protectors of the family. This programme can be seen as contributing to expand the notion of fatherhood, to include emotional support and the performance of housework. This expanding notion of fatherhood can be seen as a

combination of dominant ideals about fathers as the providers, decision-makers and protectors of the family, and subordinate models which define pregnancy, childbirth and housework as women's responsibilities (Demetriou, 2001; Connell & Messerschmidt, 2005). However, this expansion of fatherhood, similar to what has been indicated above may not disrupt masculine domination (Bourdieu, 2001). This is because the expanded practice of fatherhood may be seen as a way of asserting masculinity and dominance over women rather than the equal sharing of domestic and reproductive responsibilities.

It is worth noting that in this study, definitions of masculinities related to pregnancy and childbirth revolve around men's roles as providers, decision-makers and protectors of their families. Femininities are defined in relation to women's roles in the domestic and reproductive arena. However, this delineation is more of an ideal than actual practice because these roles overlap in marriages, especially during pregnancy, childbirth and the postpartum period. Furthermore, the practices of fatherhood and motherhood discussed in this study are not particular to Ghana. This is because some lessons and ideas at the pregnancy school, where some of these practices are conveyed, are influenced by global health discourses related to involving men in maternal healthcare (UN, 1995; UNFPA, 2004; 2007; 2010; 2011). Hence, concepts of motherhood and femininities and fatherhood and masculinities in relation to pregnancy and childbirth in the Western and non-Western contexts may influence each other. In this regard, it may not always be the case that Western concepts cannot be used to explain events in the African context as cautioned by some African scholars (Oyewumi, 1997; Lindsay & Miescher, 2003).

However, in Accra, as the three previous chapters have explored, there are multiple practices and compromises which couples make according to their specific circumstances such as housing arrangements, work situation and kinship composition. In involving men in maternal healthcare, couples engage dominant gender ideals in a complex of subordinate and complicit masculinities and emphasized, resistant and co-operative femininities (Connell, 1987; 1995). Men and women's engagement with dominant gender practices could also be related to individual's investment in subject

positions (Moore, 1994). For instance, it is no longer enough for fathers to be described as good fathers by providing for the household. Subsequently, some fathers perform housework during pregnancy and childbirth, and participate in antenatal, delivery and postnatal clinics as well as pregnancy classes. This could be a way of claiming relatedness to their children and also investing in their subject positions as the good father (Moore, 1994; Middleton, 2000). At the same time, men and women desire to meet up with the dominant social expectations of a good wife and mother; a good father and head of the family (Moore, 1994). In this regard, couples share household obligations such as provision for the family and perform household chores such as cooking, washing and shopping in a way that others may not see who does what.

From the discussions in this study, it could be inferred that involving men in maternal healthcare could be achieved to some extent but this may not change dominant gender ideals about the household and reproductive responsibilities immediately. As men are encouraged to participate in maternal healthcare, it is important to explore ongoing practices and motivations of fathers in maternal healthcare in the household and at health facilities. This could be useful in guiding and strengthening programmes designed to involve men in maternal healthcare in new and already opened avenues. In this regard more studies could be conducted. Some of these studies could focus on other parts of the country, for instance in smaller towns and villages and also focus on communities with and without pregnancy schools. In addition, single mothers and older female relatives could be included as participants in future studies. This would make room for conducting critical and comparative analysis which could assist in strengthening efforts towards male participation in maternal and reproductive healthcare.

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APPENDIX 1

A. In-depth interviews with mothers and fathers

Gender	Age	Marital Status	No. of Children	Educational Background	Occupation	Residence	Home Town
F	27	M	3	Tertiary	None	Lashibi	Kpedze
F	28	M	1	Tertiary	Technician	La-Accra	La-Accra
F	39	M	3	Tertiary	Secretary	Kaneshie	Somanya
F	32	M	2	JHS	Hairdresser	Nungua	Accra
F	32	M	3	JHS	Hairdresser	Kasoa	Kwahu
M	32	M	1	Tertiary	Engineer	Teshie	Ho
M	36	M	2	Tertiary	Police	Teshie	Boso
M	31	C	None	SHS	Salesman	Cantonments	Battor
M	26	C	2	SHS	Carpenter	La-Accra	Accra
M	27	M	1	JHS	Driver	Amasaman	Anloga
F	40	M	4	None	Trader	Cantonments	Ho

Source: Fieldwork in Accra, June to August, 2012.

B. Background interviews

Gender	Age	Marital Status	No. of Children	Educational background	Occupation
F	50	Married	2	Tertiary	Nurse-midwife
M	28	Single	None	Tertiary	Community Nutritionist
F	40	Married	2	Tertiary	Social Psychologist
F	50	Single	2	Tertiary	Public Health Nurse

Source: Field work in Accra, June to August, 2012

C. FGD 1

Gender	Age	Marital Status	Number of children	Educational Background	Occupation	Residence	Hometown
F	24	M	None	SHS	Beautician	La	Akyem
F	25	C	None	JHS	Seamstress	La	Nkonya
F	20	Engaged	None	SHS	Student/Secretary	New Town	Kumasi
F	36	M	3	JHS	Seamstress	La	Ahanta
F	26	C	None	SHS	Trader	Santa Maria	Ada
F	27	M	None	Tertiary	Human Resource Personnel	Kasoa	Upper East
F	33	M	2	JSS	Hairdresser	Otsebi	Atebubu

Source: Field work in Accra, 17th July, 2012.

D. FGD 2

Gender	Age	Marital Status	No. of children	Educational Background	Occupation	Residence	Hometown
F	35	M	2	None	None	Latebiokoshie	Bolga
F	23	M	None	Tertiary	Teacher	Abelemkpe	Bekwai
F	24	M	1	None	Hairdresser	Newtown	KeteKrachie
F	27	M	None	JHS	Hairdresser	Nungua	Accra

Source: Field work in Accra, 24th July, 2012.

E. FGD 3

Gender	Age	Marital Status	No. of children	Educational background	Occupation	Residence	Hometown
F	22	M	None	SHS	Beautician	Adenta	Accra
F	21	M	None	SHS	Hairdresser	Madina	Accra
F	20	M	None	SHS	None	Osu	Volta Region
F	32	M	2	SHS	Trader	La	Volta Region
F	25	M	1	SHS	Teacher	Sakumono	Volta Region
F	25	M	2	SHS	None	La	Krobo
F	34	M	4	SHS	Fashion Designer	Newtown	Volta Region
F	25	M	3	SHS	None	La	Accra

Source: Fieldwork in Accra, 25th July, 2012.

F. FGD 4

Gender	Age	Marital Status	No. of Children	Educational Background	Occupation	Residence	Hometown
F	41	M	8	JHS	None	East Legon	Volta Region
F	26	M	1	Primary	None	Adenta	North
F	28	M	1	JHS	None	La	Accra
F	26	M	3	JHS	None	Dzorwulu	North
F	27	M	2	JHS	None	Newtown	North
F	26	M	2	JHS	None	Madina	Akuapem

APPENDIX 2

A. Consent for Interviews and focus group discussions (Silverman, 2010)

I am Gloria Ampim, a Masters student from University of Bergen, Norway. I am studying men's contribution towards women's health issues. As a result, if you permit me, I would like to have a discussion with you about how men help their partners when they are pregnant, in labour and after the new baby is born. You are free to participate in this study and you can also decide to withdraw now or during the discussion if you feel uncomfortable with any question that we will discuss. I will not record your name and I will treat everything we discuss here confidential without divulging it to others in the community or the public except people directly involved with my project like my advisor and other faculty members. You may not benefit directly by participating in this study. But the findings of the study will help to understand men's issues in terms of supporting their partners during and after pregnancy in order to suggest ways of improving their support to improve maternal healthcare in Ghana. If you are interested in this study, then we can start our discussion.

B. Interview guide for fathers

Can you please tell me a bit about yourself and family? Probe for kinship, when she/he married, kind of marriage, age, household arrangement, work, income, education, ethnicity and class?

Do you think there are specific tasks for men and specific tasks for women?

Can you please tell me which tasks men should perform and which tasks they should not? Why?

Can you please tell me which tasks women should perform and which tasks they should not? Why?

Do these tasks change when they get married? Why?

What do you think people will say or think when men perform roles reserved for women and vice versa?

Can you please tell me the roles of a father?

What is it that makes a father? What is a father's contribution to making a baby?

How should men support their partners when they are pregnant or have a baby?

Can you please tell me how you supported your wife/partner when she was pregnant and during labour?

Which activities do women perform when they are pregnant? Why? (Probe)

So please tell me which activities your wife/partner performed when she was pregnant? Why (Probe)

Who decided where and when your wife should seek healthcare for antenatal, delivery and postnatal? Woman herself, other relatives or partner? Why? (Probe)

Whose advice does your partner/wife take when she is pregnant or has a baby? Health workers, husband or family members?

Did you have relatives coming in to help or did your wife reside with her parents when she was pregnant? Why?

How did you feel about this?

How much is spent on food, cloth, shelter, nutrition, health etc.? Did this change when the family is/was expecting a baby? Why (Probe)

What should a woman eat when she is pregnant? Why?

What shouldn't a woman eat when she is pregnant? Why not?

What did your wife eat or what is she eating?

Please tell me some of the things you know?

Do you think you are well informed about women's health when they are pregnant, in labour or just have a baby?

How did you learn about these issues?

Did you attend antenatal clinic and pregnancy school with your wife? Why?/Why not?

How did you feel when you attended the antenatal clinic and pregnancy school? Some men say they feel shy, did you feel the same?? Why or why not??

Did you attend the labour/delivery session? Why?/ Why not?

Would you like to be in the labour ward with your wife when she is having a baby? Why?

Do you think men will be happy if they are allowed to stay with their wives in the delivery room??

How do you think this will affect men's feelings and behaviour about their partners and children??

Would you permit your wife to get on family planning?? Why or why not?

Do you communicate with your wife about her experiences at antenatal clinic, labour ward and postnatal clinic? Why? Probe for examples.

How do you describe your experiences/feelings when your wife is pregnant, in labour or just delivered?

Has these experiences affected your decisions/concerns about her health or number of children you want to have? (Probe for specific examples of decisions or discussion related to the experience)

Do you have some questions or do you need clarity on something? Do you have anything you will like to add to what you have said?

Thank you very much for participating!

C. Interview guide for mothers

Can you please tell me a bit about yourself and family? Can you please tell me a bit about yourself and family? Probe for kinship, when she/he married, kind of marriage, age, household arrangement, work, income, education, ethnicity and class?

Can you please tell me which tasks men should perform and which tasks they should not? Why?

Can you please tell me which tasks women should perform and which tasks they should not? Why?

Do these tasks change when they get married? Why?

What do you think people will say or think when men perform roles preserved for women and vice versa?

Can you please tell me the roles of a mother?

What is it that makes a mother? What are the contributions of a mother to making a baby?

Can you please tell me the roles of a father?

What is it that makes a father? What is a father's contribution to making a baby?

How should men support their partners when they are pregnant or have a baby?

Can you please tell me how your husband/partner supported you when you were pregnant and during labour?

Which activities should women perform when they are pregnant? Why? (Probe)

So please tell me which activities you performed when you were pregnant? Why (Probe)

Who decided where and when you should seek health care for antenatal, delivery and postnatal? Woman herself, other relatives or partner? Why? (Probe)

Whose advice do you take when you are pregnant or have a baby? Health workers, husband or family members?

Did you have relatives coming in to help or reside with your parents when you were pregnant? Why?

How did you and your husband/partner feel about this?

How much is spent on food, cloth, shelter, nutrition, health etc.? Did this change when the family is/was expecting a baby? Why (Probe)

What should a woman eat when she is pregnant? Why?

What shouldn't a woman eat when she is pregnant? Why not?

What did you eat or are you eating?

Do you think you are well informed about women's health when they are pregnant, in labour or just have a baby?

What about your husband? Is he well informed as well?

Please tell me some of the things he knows?

How did he learn about these issues?

Did your husband/partner attend antenatal clinic and pregnancy school with you? Why?/ Why not?

How do men feel when they attend the antenatal clinic and pregnancy school?

Do you think it is because there are a lot of women at the antenatal clinic that most do not show up??

Would women like their partners to be in the labour ward with them when they are having a baby and not just sit outside?? Why

Would you like your husband to be in the labour ward with you??

Do you think men will be happy if they are allowed to stay with their wives in the delivery room??

How do you think this will affect men's feelings and behaviour about their partners and children??

Are men permitting their partners to get on family planning?? Why or why not?

Can you please tell me about your personal experience??

How did you experience labour/ delivery?

Do you communicate with your husband about your experiences at antenatal clinic, labour ward and postnatal clinic? Why? Probe for examples.

How would you describe your husband's feelings when you were pregnant, in labour or just delivered?

Has these experiences affected the family's discussion about your health or number of children in the family? (Probe for specific examples of decisions or discussion related to the experience).

Do you have some questions or do you need clarity on something? Do you have anything you will like to add to what you have said?

Thank you very much for participating!

NB: In case participants are currently expecting a baby, I will ask the questions in the present tense to correspond with what is happening currently and will probe for what happened in the past if they already have a child.

D. Interview guide for background informants

Can you please tell me a little about yourself? Probe for age, position, education, ethnicity, and class?

Can you please tell me what family life is like in this community?

Who makes decision in the home? Men or women? Or Extended family members like mother-in-law, father-law etc. Why? Probe.

Whose advice do women take? Health worker, husband, family members etc? Why? Probe

What do you see happening?

What should women eat when they are pregnant and what shouldn't they eat?

Do you think women eat these things or they don't?

Do you think men feel ok when relatives move in to stay with them because their wife is pregnant or has a baby? Probe

Are men knowledgeable on women's health issues?

Where do they get informed?

What are the activities that a woman performs when she is pregnant and when she has a baby?

What kind of support do men give during and after pregnancy?

Where do women mostly go for ANC and delivery?

Do their partners and husbands go with them to ANC/delivery? Why?

How do men feel when they attend the antenatal clinic?

Do you think it is because there are a lot of women at the antenatal clinic that most do not show up??

Would women like their partners to be in the labour ward with them when they are having a baby and not just sit outside?? Why?

Would you like your husband to be in the labour ward with you??

Do you think men will be happy if they are allowed to stay with their wives in the delivery room??

What about when a woman delivers at home or with a TBA? Are men allowed to be present? Why?

How do you think this will affect men's feelings and behaviour about their partners and children??

Are men permitting their partners to get on family planning?? Why or why not?

Do men communicate with their partners about things which happen during ANC/delivery? Why?

Do you think household relations and arrangements are changing?

What do you think are the causes of these changes?

Do you think maternal health issues are changing?

What do people think about these changes?

Do you have any question or do you want clarity on any issue? Do you have something to add to what you have said?

Thank you very much for participating!

E. **Guide for focus group discussion 1 and 2**

Rules for focus groups

- No mention of names
- Respect for each other's opinion even if we disagree
- Wait for one person to finish before you contribute even if you disagree.

How is family life in this community?

Which tasks should men perform and which tasks shouldn't they perform? Why?

Which tasks should women perform and which tasks shouldn't they perform? Why?

Do these tasks change when they get married? Why?

Do you think household arrangements are changing in recent times?

What do you think are the causes of these changes?

What do people think about these changes?

What are the roles of a father?

What is the contribution of a father to making a baby?

What are the roles of a mother?

What is the contribution of a mother to making a baby?

Who makes decision in the home? Men or women? Or extended family members like mother-in-law, father-law etc.

Whose advice do women take when they are pregnant or have just delivered? Health worker, husband, family members? Why? Probe

What should a woman eat when she is expecting a baby or has a baby? Who decides?

What shouldn't a woman eat when she is expecting a baby or has a baby? Who decides?

So do you think women eat what they have to eat? Why?/ Why not?

What are the activities that a woman performs when she is pregnant and when she has a baby? Why? Probe

What do you see happening?

Are men knowledgeable on women's health issues?

Where do they get informed? Health facility, family members, friends, church etc?

What is a man's responsibility when his partner is pregnant, in labour or has a new baby?

Are men performing these responsibilities adequately? Why? Probe

What about the other family members like sisters, brothers, in-laws etc? What do they do to support women when they are pregnant or have a new baby?

Why do family members reside with couples when they have or are expecting a baby?

Do you think men feel ok when relatives reside with them because their wife is pregnant or has a baby? Probe

What about women, how do they feel when relatives reside with them because their wife is pregnant or has a baby? Probe

Do men go to antenatal clinics and pregnancy school with their partners? Why?

How do men feel when they attend the antenatal clinic?

Do you think it is because there are a lot of women at the antenatal clinic that most do not show up??

Would women like their partners to be in the labour ward with them when they are having a baby and not just sit outside?? Why

Would you like your husband to be in the labour ward with you??

Do you think men will be happy if they are allowed to stay with their wives in the delivery room??

How do you think this will affect men's feelings and behaviour about their partners and children??

Are men permitting their partners to get on family planning?? Why or why not?

What about when a woman delivers at home or with a TBA? Are men allowed to be present? Why?

How do you think men's support should be improved or can be changed to meet your expectations?

Do you have a question or need clarity on any issue? Does anyone want to add something to what we have discussed?

Thank you very much for participating!

F Guide for focus group discussion 3 and 4

First story

Kofi is a teacher and has been married to Efua for the past two years. Efua is pregnant and frequently ill. Kofi performs housework such as cleaning, washing, cooking and shopping. One weekend while he was shopping in the market, he met two ladies who are his colleagues at school. They laughed at him. The following week when Kofi went to school, news had spread that he performs housework and that his wife had turned him into a maid.

Are the ladies were right in laughing at him? Why? Why not?

Do attitudes like this prevent men from performing housework?

Should he continue to perform housework? Why? Why not?

Is Kofi's performance of housework enough as his form of contribution during pregnancy?

What are the roles of a father?

What are the roles of a mother?

Should men attend antenatal clinics, pregnancy schools and postnatal clinics? Why? Why not?

What about labour and delivery? Why? Why not?

Do you communicate with your partners when you return home?

Second story

Nana Ama and Francis have been married for five years. They are expecting their second child. When they were expecting the first one, Nana Ama moved out to stay with her mother. Francis performs most of the household chores and according to Nana Ama, she never knew he could cook, clean and wash until now. However, Nana Ama is contemplating moving out to stay with her mother or asking her mother to move in with them before she delivers. But she is confused about what to do.

What should Nana Ama do?

Why does she need someone to support apart from Francis?

Should she go? Why? Why not?

How will Francis take this?

Are men ok when their partners move out or having someone move in during pregnancy and delivery?

What about women? How do women feel when they have to move out or have someone move in?

Whose advice do women take when they are pregnant or have just delivered? Health worker, partner, family members? Why? Why not?

Are men knowledgeable on women's health issues?

Where do they get informed? Health facility, family members, friends, church, etc?

How do you think men's support during pregnancy and delivery can be improved?

Do you have something to add?

Do you have a question or need clarity on any issue?

Thank you very much for participating!