Transforming gender relations?

Men's involvement in care for their partners and households at the time of pregnancy in rural and urban Ghana – a qualitative study

Gloria Abena Ampim

Thesis for the degree of Philosophiae Doctor (PhD)
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Scientific environment

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Dedication

To my dear mother, Agnes Yaa Fassah, who passed away suddenly in 2002. Continue to rest in peace. Amen.

Abstract

Background to the study

Involving men in the care for their pregnant partners has been described as an opportunity for initiating new fatherhood norms and masculinities that do not thrive on the subordination of women. This understanding implies that male inclusion in the care for pregnant partners could inspire more gender-equal practices. Starting with a brief historical account of family structures and gender orders, the study focuses on current trends in household gender relations and masculine expectations in Ghana to analyse the gender-transformative potential of men's involvement in the care for their pregnant partners.

Study aims

This study was guided by the following aims, which were addressed in three peer-reviewed articles: to explore how social expectations and actual practices of fatherhood interact with conceptions and norms of manhood and masculinity; to shed light on men's experiences of antenatal care services and how these experiences are influenced by hegemonic masculine expectations and the gendered construction of space; to investigate how increased male participation in domestic work during pregnancy relate to and possibly challenge cultural expectations of manhood and womanhood.

Methods

A qualitative study combining phenomenological and ethnographic approaches was conducted in Accra and the Afram Plains North District of Ghana. Thirty-one semistructured interviews with fathers, mothers, health workers and background informants, seven focus group discussions with mothers, fathers and community health nurses, and various observations over seven months in Accra and one month in Afram Plains were conducted. Semistructured interviews and focus group discussions used a topic guide that centred on the following key areas: fatherhood and masculine norms and expectations in the Ghanaian social context; men's

roles and responsibilities during pregnancy; men's practical daily routines during the time of pregnancy; men's experiences of maternal health services; and social support for expecting nuclear families. Thematic analysis was used to process and analyse the data material.

Findings

Article I

This first article explores the transition of young men from boyhood to manhood and its connections to the expectations of becoming and being a father. The findings were framed within the analytical discussion of hegemonic masculinity, postcolonial perspectives of masculinities in Africa, and emergent masculinities. The findings showed that boys are expected to become men by maintaining intimate relationships, providing for their nuclear families and kin, and having biological children. This expectation was described as synonymous with what postcolonial scholars have called adult masculinity. The article further argued that since adult masculinity appeared to be highly valued by the young fathers studied, it could be referred to as the hegemonic masculinity. The narratives additionally indicated that it is becoming expected for men to carry out household chores, show respect and affection for their partners and spend time with their nuclear families. These additional expectations were analysed as elements of involved fatherhood and emergent masculinities.

Article II

This second article illuminates the experiences of men who accompanied their expectant partners to antenatal care (ANC) services in Accra. The findings showed that most men who attended ANC with their partners were reluctant to stay in the waiting area of the maternity clinic where services were ongoing because they were shy and uncomfortable about being in a space where women outnumbered men. Men talked about their motivations for attending ANC, which were to learn and remind their partners of essential health messages and to show love, support and respect to pregnant partners. Health workers did not have specific guidelines about

the inclusion of men in ANC services, except for giving preferential treatment to women accompanied by men. Discussing the findings with the concept of space, place and gender suggested that the maternity clinic has been constructed as a feminine space over time, limiting men's integration and participation in the activities that unfold during ANC.

Article III

This third article investigates alterations in gendered division of household labour during the time of pregnancy and the potential resistance to permanent changes in conventional gender norms. The findings indicated that men increased their participation in housework during their partner's pregnancy. Nonetheless, both men and women maintained that men should not carry out most or all the housework because doing so could inspire laziness among women. Thus, both men and women accentuated that men's participation in domestic work should be a form of support given to expectant mothers when they were tired or experiencing complications, but should not become normative. Using the theories of '(un) doing gender', the article suggested that men's involvement in housework is a temporary response to a specific life change, which does not seem to imply a possible permanent transformation in the gendered division of household labour.

Discussion

The findings of the thesis demonstrate multifaceted involvement of men in the care for their pregnant partners, norms of involved fatherhood, elements of masculinities that do not thrive on the subordination of women, and tentative modifications in the gendered division of household labour during the time of pregnancy. Men played a plethora of roles in the households and in the health facility setting to promote positive health outcomes for their pregnant partners, such as providing financial resources and increasing participation in housework. Male participants also practised or imagined themselves enacting elements of

involved fatherhood, which means providing hands-on care for their children, playing with them, and spending quality time with their nuclear families. Hegemonic masculinity, coined as adult masculinity, persisted and is exemplified in the expectation for adult males to maintain stable intimate relationships, provide for their nuclear families, and have biological children. Moreover, men's roles during pregnancy, like providing financial resources and attending ANC to remind their partners of important health messages and ask questions that their partners could not ask, appeared as further articulations of hegemonic masculinity. Concurrently, men's expression of the value of conjugal fidelity, the importance they give to showing love and affection for partners, spending time with the nuclear family, and their willingness to perform some amount of housework show emergent masculinities and norms of involved fatherhood.

Men and women's participation at ANC shows that the maternity clinic has been constructed as a feminine space and a 'third place' for expectant mothers during the period of pregnancy. Women create social networks and connections during ANC services and discuss their health without the interference of male partners. Although men's attendance at ANC services is recognised as important for providing physical and emotional support to expectant mothers, policies that incentivise men by giving preferential treatment to women accompanied by their partners are discriminatory against women who attend ANC alone. Hence, men's active participation in ANC remains a dilemma. Increased men's attendance and active participation in ANC services may dissolve the maternity clinic as a space where expectant mothers connect with each other and exercise autonomy over their health. At the same time, ineffective engagement of men at ANC services may marginalise men who want to be actively involved and likewise hinder the opportunity to garner men's support as allies and equal caregivers to pregnant partners.

The conceptual framework of '(un)doing gender' was employed to interpret findings concerning transformations of gender relations. Examples of both 'doing' and 'undoing gender'

were encountered in the study findings. Normative gender expectations that were understood as scripts for 'doing gender' described men as the key breadwinners and women as responsible for housework, even if women were engaged in income generating activities outside the home. However, during the period of pregnancy, both urban and rural men were willing to intensify their participation in domestic work, which suggests some amount of 'undoing gender'. There was opposition to prospective long-term adjustments in gender norms. Participants contended that men should not do all or most of the housework because it could generate misunderstandings in intimate relationships and destabilise harmony in the household. It appeared that it is still essential for men and women to accomplish gender in conformity to the male breadwinner and female domestic-caregiver model. Nonetheless, men's participation in housework during their partner's pregnancy implies that they may become more skilful and competent in performing housework, and subsequently, perform domestic chores more easily, thereby reducing women's burden of combining domestic and waged labour.

Conclusion

The likely resistance to permanent change in gender norms and practices in the household, even during the time of pregnancy, suggests that involving men in the care for their pregnant partners may not radically transform gender relations. Yet the manifestation of emergent masculinities and norms of involved fatherhood indicate a gradual process of change towards dismantling the unequal gender system.

List of abbreviations

ANC – Antenatal Care

CHN – Community Health Nurse

CHPS – Community-based Health Planning Services

CHRAJ – Commission of Human Rights and Administrative Justice, Ghana

FGD – Focus group discussion

GHS – Ghana Health Service

GSS – Ghana Statistical Service

ICPD – International Conference on Population and Development

MoGCSP – Ministry of Gender, Children and Social Protection, Ghana

MOH – Ministry of Health, Ghana

MOWAC – Ministry of Women and Children's Affairs, Ghana

NGOs – Non-governmental Organisations

NWCD – National Council of Women and Development

SAPs – Structural Adjustment Programmes

SHOW – Strengthening the Health of Women and Children

TA – Thematic Analysis

UN – United Nations

UNDP – United Nations Development Programme

UNFPA – United Nations Fund for Population Activities

WHO – World Health Organisation

List of publications

Article I

Ampim, G. A., Haukanes, H., & Blystad, A. (2020). Making Fathers: Masculinities and Social Change in the Ghanaian Context. *Africa Today*, *67*(1), 24-47. https://doi.org/http://dx.doi.org/10.2979/africatoday.67.1.03

Article II

Ampim, G. A., Blystad, A., Kpoor, A., & Haukanes, H. (2021). "I came to escort someone": Men's experiences of antenatal care services in urban Ghana—a qualitative study. *Reproductive Health*, *18*(1), 106. https://doi.org/10.1186/s12978-021-01152-5

Article III

Ampim, G.A., Haukanes, H., Blystad, A., & Kpoor, A. 'I do not want her to be doing anything stressful': Men's involvement in domestic work during pregnancy in Ghana. Resubmitted based on minor revisions to *Progress in Development Studies, Sage on 18th January 2022*

Contents

1 Introduction

1.1 Background to the study

Our knowledge about men's inclusion in sexual and reproductive health matters can be traced back to the United Nations International Conference on Population and Development (ICPD) held in Cairo in 1994 (Agyare et al., 2018, p. 62; Galle et al., 2021; Gopal et al., 2020, p. 2). ICPD 1994 argued that since men played key decision-making roles ranging from personal decisions about the size of families to national and global level decisions, they should also be actively engaged in gender equality agendas (UN, 1995, p. 27). Action areas emphasised by ICPD 1994 about men's engagement included the global promotion of men's shared responsibility in parenting, sexual and reproductive practices like contraception use, antenatal care (ANC), maternal and child health, and the prevention of sexually transmitted infections (UN, 1995, p. 27). Following ICPD 1994, many international agencies, including the World Health Organisation (WHO), United Nations Fund for Population Activities (UNFPA), national governments, and many non- governmental organisations (NGOs) have mobilised resources to include men in reproductive health initiatives (Gopal et al., 2020, p. 2; WHO, 2002).

In Ghana, policies and programmes about men's involvement in reproductive health initiatives have included behaviour change communication campaigns that encourage the use of contraceptives, campaigns emphasising men's shared responsibility in the prevention of HIV/AIDS, and campaigns to inspire men's access to and use of reproductive clinics (MOH, 2009, p. 25; Odoi-Agyarko, 2003, p. 29). A substantial body of research in Ghana has focused on including men in ANC, supervised delivery, postnatal care, and child health services (Aborigo et al., 2018; Agyare et al., 2018; Atuahene et al., 2017; Craymah et al., 2017; Doegah, 2019; Ganle & Dery, 2015; Quarcoo & Tarkang, 2019). The findings of these studies have

consistently shown that men's active involvement in reproductive health services have remained low in Ghana (Aborigo et al., 2018; Atuahene et al., 2017; Quarcoo & Tarkang, 2019).

Globally, an increasing number of studies have shown that men's increased involvement in reproductive healthcare can improve health outcomes for women and children (Ampt et al., 2015; Comrie-Thomson et al., 2015; Davis et al., 2016; Dudgeon & Inhorn, 2004; Ladur et al., 2021; Yargawa & Leonardi-Bee, 2015). Women's access to material resources for healthcare in many parts of Sub-Saharan Africa has been explained as influenced by men, and therefore, it was thought that involving men would inspire their material support during pregnancy (Dahab & Sakellariou, 2020; Galle et al., 2020; Ganle & Dery, 2015; Yargawa & Leonardi-Bee, 2015). In the context of HIV/AIDS, men's participation in the care for their pregnant partners has been identified as enhancing women's decisions to be tested for HIV/AIDS, which has bolstered adherence to antiretroviral among HIV/AIDS-positive expectant mothers (Chibango, 2020; Hampanda et al., 2019; Matseke, Ruiter, Rodriguez, et al., 2017; Rodriguez et al., 2020).

Additionally, it is presumed that mental and emotional health of women during pregnancy and after childbirth can be improved when they receive support and care from their intimate partners (Alemann et al., 2020; Davis et al., 2016; Drysdale et al., 2021). Furthermore, involving men in the care for pregnant partners has been described as an opportunity to initiate new fatherhood norms, practices and masculinities that do not thrive on the subordination of women (Alemann et al., 2020; Comrie-Thomson et al., 2019; Doyle et al., 2014; Doyle et al., 2018; Duch et al., 2019). Thus, men's participation in the care for their pregnant partners could inspire more gender-equal practices and relationships (Comrie-Thomson et al., 2015; Levtov et al., 2014). Subsequently, researchers have suggested that gender should be more integrated into the

analysis of men's roles during pregnancy to understand the gender-transformative potential of male involvement initiatives (Comrie-Thomson et al., 2015, p. 186).

An investigation of the gender-transformative effect of men's inclusion in the care for their pregnant partners invites a discussion of the norms of fatherhood and masculinity in the context under study to enhance the understanding of men's roles, experiences and practices during pregnancy (Doucet, 2013; Plantin et al., 2011, p. 97). Using qualitative data collected in Accra and Afram Plains, this study attempts to respond to the call for more explorations of the gender-transformative potential of involving men in the care for pregnant women from both rural and urban perspectives. Before outlining the study's objectives, I provide a brief sketch of the development of gender orders in Ghana (including the expectations of fatherhood and motherhood) from precolonial to present times, and outline current trends in gender norms and practices in the family setting.

1.2 Gender relations and family structure in Ghana

1.2.1 Precolonial Ghanaian contexts

Some knowledge of Ghanaian societies prior to imperial domination is accessible through the anthropological studies of Meyer Fortes and R.S. Rattray (Fortes, 1949; Rattray, 1927). These and other anthropological studies provided opposing accounts of the social relations in the matrilineal and patrilineal societies in Ghana. The gender relations in precolonial Ghanaian contexts are reported as complementary without profound sex discrimination, indicating that women and men carried out similar social and political roles (Dery & Bawa, 2019; Oppong, 1980). In the matrilineal societies, women remained part of their own lineage after marriage and children belonged to their mother's lineage (Clark, 1994; Oppong, 1980; Rattray, 1927). Paternity was nonetheless described as remaining important and integral to the social upbringing and status of children (McCaskie, 2015; Nukunya, 2016). Women brought up girls

and men brought up boys in a manner where children received daily instructions from their parents and elders, especially, elders from the matrikin, and learned through imitation (Allman, 1997; Miescher, 2005, p. 18). Fatherhood was a continuous process of negotiation between biological fathers and their children's matrilineage, whereby fathers gained the right of use of their children's services as long as they fulfilled obligations of care and training (Allman, 1997, p. 302). Thus, fathers could lose their children to the matrikin when they did not meet their obligations (Allman, 1997).

Some precolonial patrilineal societies showed a palpable distinction of roles for men and women. Fathers in patrilineal contexts like the Tallensi and Ewe symbolised an ideal patriarch who was the decision-maker, breadwinner and protector of his wife and children (Fortes, 1949, p. 101; Nukunya, 2016). Mothers symbolised the ideal caregiver responsible for housework and childcare, and women were required to call their husband "master" and submit to their authority (Fortes, 1949, p. 101; Nukunya, 2016, p. 59). Among the Tallensi, for example, Fortes (1949, p. 102) showed that a man had the right to his wife's labour on farms and in turn husbands provided wives with shelter, healthcare, and paid her debts. Fortes (1949, p. 102) also recorded that it was possible for women to gain their own plots of land from their fathers, brothers or husbands, which they owned and cultivated independently. Women supplemented household resources with the harvest of their fields and sometimes could barter this harvest for items as they pleased (Fortes, 1949, p. 102). Children in patrilineal societies belonged to their father's lineage and were trained and socialised by parents, extended families and the entire communities (Dery & Bawa, 2019; Nukunya, 2016).

1.2.2 Colonial and early postcolonial developments

Starting in the 1920s, scholars have identified a number of developments (like cocoa farming, Christianity, colonial administrative practices, and Western education) that have fragmented

established social norms in both matrilineal and patrilineal societies (Allman, 1997; Hawkins, 2002; Miescher, 2003; Nukunya, 2016; Oppong, 1980; Tashjian & Allman, 2002). The expansion of cocoa farming as a cash crop after the 1920s prompted contestations of socio-cultural norms in matrilineal cocoa farming communities (Allman, 1994, p. 27; Tashjian & Allman, 2002). The labour of children and wives became important in the cultivation of cocoa farms, and hence, husbands became obliged to continuously provide for the upkeep of women and children as a form of compensation for their labour (Allman, 1997, p. 306). Additionally, wives and children began asking to inherit portions of their husbands' and fathers' cocoa farms because of their contribution to the wealth (Allman, 1997, p. 306).

The formation of marriage under colonial rule came to be known in different forms as customary marriage, marriages blessed in the church, partially formalized concubinage, and ordinance marriage (Miescher, 2003, p. 98). The doctrine of the Presbyterian Church, for example, forbade polygamy, which was customarily accepted, and preferred to recognise monogamous marriages only (Miescher, 2003, p. 98). In the matrilineal society, marriage ordained by the church or/and by ordinance implied that children inherited from their fathers rather than their maternal uncles. Marriage by the Church and ordinance were both more likely to be practised among young and European-style educated Ghanaians than the older generation (Miescher, 2003). Subsequently, as indicated in the literature, men and women lived with complex, overlapping processes of marriage and inheritance (Allman, 1997; Miescher, 2003, p. 99; Tashjian & Allman, 2002).

Historical accounts have indicated that gender norms with distinct tasks for men and women in colonial Ghana were mainly spread through education, in both European-style schools and apprenticeships (Dery & Bawa, 2019; Miescher, 2005). Women's welfare, rights, and long-standing roles in economic and political participation were of minimal interest to the colonial administration (Allman, 1994; Bosak et al., 2017; Dery & Bawa, 2019; Hawkins, 2002, p. 124).

Girls were trained by missionaries and the schools to become “proper” mothers and wives to care for their homes and train their children (Allman, 1994, p. 25). Boys were trained to become employed by the government or church, enter monogamous conjugal unions, and provide for their wives and children with reduced support for their lineage (Miescher, 2005, pp. 70-71). It thus became expected that fathers would pay for school fees, apprenticeship and training, and the clothing and feeding of their children (Allman, 1997, p. 313; Miescher, 2005, p. 50). At the same time, in colonial Asante, for example, fatherhood as a continuous process of negotiation between biological fathers and the children’s matrikin began to disappear once biological fathers came to assume inalienable rights over their children (Allman, 1997, p. 312). The matrikin’s support for childcare weakened because men had to focus on their biological children. In some cases, it was difficult to hold biological fathers accountable for obligations towards their children, and mothers had to take up the responsibility of providing for and training their children without the father’s support (Allman, 1997, p. 313).

The early independent period witnessed the establishment of the National Council of Women (1960), which was intended to strengthen vocational training for women and increase childcare facilities across the country to support mothers who were engaged in work outside the home (Ayentimi et al., 2020, p. 70). The role of fathers in domestic work and childcare was invisible during this period. The late Professor Fred Sai, a renowned reproductive health leader, who then worked at the Princess Marie Louise Children’s Hospital in Accra in the early postcolonial period, noted in his memoir that, at the time, fathers did not even visit their sick children admitted at the hospital (Sai, 2010, p. 67). This comment in Fred Sai’s memoir gives an impression of the minimal role of fathers in giving hands-on care to their children during the early postcolonial period.

1.2.3 Recent developments and current trends

The implementation of structural adjustment programmes (SAPs) in the 1980s spawned a situation of low wages and high unemployment among men in Ghana (Ayentimi et al., 2020). Subsequently, men were often unable to perform their culturally-defined roles of providing the family's income (Ayentimi et al., 2020; Boni, 2002; Clark, 1999; Overå, 2007). In the marketplaces, men joined petty trading, work which had formerly been described as 'feminine' (Overå, 2007, p. 559). In the family setting, women began performing breadwinning roles for their nuclear families while some men became more involved in doing housework such as cooking (Boni, 2002; Clark, 1999).

The UN Decade of Women (1975 to 1985) and the World Conference on Women (Beijing 1995), have contributed to changing the status of Ghanaian women through the introduction of new 'women friendly' laws and policies (Adomako Ampofo & Boateng, 2007; Bosak et al., 2017; Manuh, 2007). In the wake of the UN Decade of Women, laws and policies such as the Domestic Violence Act and the Gender and Agricultural Development Strategy were installed to enhance women's rights (Bosak et al., 2017, p. 117). Following Beijing 1995, the National Council of Women and Development (NCWD), now called the Ghana Department of Gender (DOG), was created with regional representation throughout the country (MoGCSP, 2015, p. 2). The Department of Gender was responsible for social and economic mobilisation of women, including boosting access to micro credit and social protection. In 2001, a full-fledged ministry named, the Ministry of Women and Children's Affairs was established (MOWAC) to mainstream gender issues into national development agendas (MoGCSP, 2015, p. 2).

Women's participation in waged labour increased tremendously starting in the 1970s (Bosak et al., 2017, p. 117). Statistics from Accra and the Afram Plains North District where the data for this study was collected show an almost equal engagement in economic activities outside the home for both men and women. The 2010 National Population Census found that 92.6% of

males and 91.8% of females were employed in Greater Accra (GSS, 2013b, p. 76). In the Afram Plains North District, 98.7% of males and 98.4 % of females were employed (GSS, 2014, p. 33).

Despite women's intense participation in economic activities, normative local prescriptions of what makes a 'proper' woman and what makes a 'proper' man received minimal revisions (Adomako Ampofo, 2001; Adomako Ampofo & Boateng, 2007; Sossou, 2003). Women were still expected to accomplish gender by doing most of the housework while men were expected to accomplish gender by providing for and leading the household (Dako-Gyeke & Owusu, 2013; Sossou, 2003). A number of authors have shown that women's burden of combining family work and waged labour increased without a corresponding increase in their access to resources or decision-making power in the household and society (Avotri & Walters, 1999; Lloyd & Gage-Brandon, 1993; Waterhouse et al., 2017). Thus, women's increased participation in work outside the home arguably yielded minimal equality in gender relations in the domestic sphere.

Policies over the last couple of years have shown more initiatives that seek to scale-up activities to promote gender equality and equity in Ghana. The Ministry of Gender, Child, and Social Protection (MoGCSP), which replaced the Ministry of Women and Children's Affairs (MOWAC) in 2013, commits to promoting gender equality in education, labour and employment, and political representation (MoGCSP, 2015, p. 32). A National Gender Policy that was finalised in 2015 characterised the government's commitment to gender equality as "*mainstreaming gender, women's empowerment and social protection concerns into the national development process in order to improve the social, legal, civic, political, economic and cultural conditions of the people of Ghana*" (MoGCSP, 2015, p. 23). The policy framework is described to liaise with employers to support the balance of work and family responsibilities, including by providing of child-friendly facilities at workplaces (MoGCSP, 2015, p. 32). Some

progress has been recorded around men's inclusion in postnatal care through the provision of paternity leave. Some private institutions and multinational organisations, like international NGOs, give paternity leave to their employees (Anku-Tsede et al., 2018, p. 116). Paternity leave is also indicated as being part of the collective bargaining agreement of the public sectors in health, education and mining (Anku-Tsede et al., 2018, pp. 116-117).

Social research from the past ten years has indicated adjustments in the division of household labour among intimate partners. In urban areas, especially, more and more women work outside the home for long hours, nuclear families have become increasingly common, and kin support for childcare and housework has dwindled (Badasu, 2004; Kpoor, 2015; Manful & Cudjoe, 2018; Oppong, 2012). Subsequently, it is becoming more common for men to perform housework and give care to their children (Dery & Akurugu, 2021; Ganle, 2015; Kwansa, 2012). Following seeming reshuffling of tasks among men and women in the domestic arenas, new fatherhood practices and new masculine practices may evolve. This study is framed around the indications of adjustments in current household gender practices and the suggestion that including men in the care for their pregnant partners could nurture new norms of fatherhood and masculine norms that can augment gender equality in the household. Studying modifications in unequal gender relations in the family setting can yield insights into men's motivations to ally or resist feminist agendas in private and public spheres (Comrie-Thomson et al., 2019; Deutsch, 2007).

1.3 Study goals and objectives

This study aims to improve our understanding about gender relations in Ghana by exploring the relationships among men's involvement in their care for their pregnant partners, fatherhood, and masculine expectations. First, the study attempts to deploy theories on masculinities to explore the interface between the constructions of masculinity, fatherhood and locally-derived

and locally-practised gendered relations in the household in urban and rural Ghana from men's own perspectives and experiences. Hence, the study endeavoured to shed light on how masculinities are conceptualised when men's roles and involvement with their intimate partners and children diverge from the local cultural scripts (Connell, 2005; Inhorn & Wentzell, 2011). Second, the study embarked on an investigation of men's experiences when they accompanied their partners for maternity care services and discusses how these experiences were influenced by the gendered construction of space and place (Massey, 1994). Thirdly, the study attempted to search for men's roles and practices during the time of pregnancy, both those that conformed to normative masculine expectations and those that did not follow these expectations (Deutsch, 2007; West & Zimmerman, 1987).

The study is guided by the following objectives:

1.3.1 Main objective

To explore how men's involvement in the care for pregnant partners interacts with multifaceted norms of masculinity and fatherhood with potential implications for transformations in gender relations.

1.3.2 Sub-objectives

1. To explore how social expectations and actual practices of fatherhood interact with conceptions and norms of manhood and masculinity (Article I).
2. To shed light on men's experiences of antenatal care services and how these experiences are influenced by hegemonic masculine expectations and the gendered construction of space (Article II).
3. To investigate men's increased participation in household chores during their partner's pregnancy and how men's roles during peak reproductive periods relate to and may challenge cultural expectations of manhood and womanhood (Article III).

In this study, the term *'men's care for their pregnant partners'* is to be understood as all the activities that men carry out in households and at health facilities at the time of pregnancy of their partners in their roles as intimate partners, husbands and fathers. I will use 'men's roles during pregnancy' and 'men's involvement/engagement in the care for their pregnant partners' interchangeably.

2 Conceptual Framework

In this chapter, I will discuss the theoretical perspectives that have framed the analytical discussion of this study. The study draws on three interlinked theories of gender, two of which are situated in the field of sociology and one in the field of feminist geography. Theories of masculinities including postcolonial perspectives (Connell, 1995; Inhorn & Wentzell, 2011; Lindsay & Miescher, 2003) form the overarching conceptual framework of the study and were used to explore current trends in young fathers' embodiments of masculinity (Article I). 'Doing' and 'undoing gender' perspectives (Deutsch, 2007; Risman, 2009; West & Zimmerman, 1987) were also incorporated to investigate continuities and changes in cultural gender scripts in Ghanaian households (Article III). Finally, conceptualisations of space, place and gender as formulated by feminist geographers (Massey, 1994; McDowell, 1999), were included to discuss how men navigate masculinity in spaces where women dominate numerically (Article II).

The three areas of scholarship incorporated in this study are connected in terms of their analytical perspectives of gender as a set of social relations, and their articulations of social structures and relations as malleable and subject to change over time. All three theories were developed in their original formulation in the 1980s, a period known for comprehensive theorisations in gender studies. This period witnessed intensive developments in our understanding of how the lives of women and men are interrelated conceptually, legally, politically, socially and culturally in a gender system (Stimpson & Herdt, 2014, p. 13). I draw on both the original formulations of the theories and their later developments.

2.1 Theorising masculinities

2.1.2 Hegemonic masculinity

Raewyn Connell and colleagues began their research on masculinities in the 1980s, which culminated in Connell's volume entitled *Masculinities* in 1995. Connell conceptualised

masculinity as defining the processes and relationships through which men and women conduct gendered lives (Connell, 2005, p. 71; Connell, 1995). Masculinity only exists in contrast to femininity and can be described as "doing gender in a culturally specific way" (Connell, 2005, p. 68). The climax of Connell's discussion of the topic is her development of the theory of hegemonic masculinity. Inspired by Anthonio Gramsci's concept of 'cultural hegemony', *hegemonic masculinity* is defined 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, 2005, p. 77).

In other words, hegemonic masculinity is the (contemporaneous) socially and culturally most venerated form of masculinity within a given pattern of gender relations (Bach, 2017; Bloksgaard et al., 2015; Newton et al., 2018). Hegemonic masculinity was theorised in order to analyse gendered hierarchies and unequal relations between men and women and among men. Unequal relations between men and women were described as *external hegemony* and unequal relations among men were categorised as *internal hegemony* (Christensen & Jensen, 2014; Demetriou, 2001; Messerschmidt, 2012). Hegemonic masculinity ascends to dominance through a cultural and discursive consensus rather than the use of explicit force (Bloksgaard et al., 2015, p. 153; Christensen & Jensen, 2014; Hearn, 2004; Messerschmidt, 2012). Hegemonic masculinity is positioned as the most valued form of masculinity in relation to other masculinities and femininities (Bloksgaard et al., 2015). Connell identifies complicit, subordinate, marginalised and protest masculinities as nonhegemonic masculinities (Connell, 1987, 2005; Connell, 1995; Connell & Messerschmidt, 2005). Connell also identifies three femininities: emphasised, resistant/non-compliant, and a combination of compliant, resistant and cooperative femininities (Annes et al., 2021; Connell, 1987, pp. 183-184; Schippers, 2007).

The concept of hegemonic masculinity has been used to illustrate the diversity and multiplicity of masculinities, to conceptualise change in leading masculine patterns, and to explore the structure of hegemony in different contexts (Bloksgaard et al., 2015; Christensen & Jensen, 2014; Connell & Messerschmidt, 2005, p. 834; Groes-Green, 2009; Hearn, 2004; Lusher & Robins, 2009; Messerschmidt, 2012; Wetherell & Edley, 1999). For example, the theory proposes that both hegemonic and non-hegemonic masculinities are open to change in a manner such that new versions may replace old ones (Connell & Messerschmidt, 2005; Messerschmidt, 2012, 2018). The multiplicity of masculinities and the envisaged transformations among various forms of manhood acts bestow the possibility of a shift in gender relations from unequal to more egalitarian practices (Messerschmidt, 2012, 2018; Schrock & Schwalbe, 2009; Sullivan, 2004).

Nonetheless, scholars have rigorously criticised the concept, among others for universalising what constitutes masculinity without providing concrete examples (Bloksgaard et al., 2015; Wetherell & Edley, 1999) and for describing a rigid border between hegemonic on the one hand and subordinate and marginalised on the other (Demetriou, 2001). Hegemonic masculinity has been further criticised for leading to an overemphasis of unequal relations between men and women and, among men, for not accounting for masculinities that do not strive to legitimise male dominance over female (Bach, 2017; Bloksgaard et al., 2015; Christensen & Jensen, 2014; Groes-Green, 2012; Hearn, 2004; Schippers, 2007).

Following the questions raised about the theory of hegemonic masculinity, Connell and Messerschmidt (2005) have acknowledged that the initial formulation of the concept is universalistic. They have suggested that researchers should explore masculinities in local contexts and clarify the dynamism of masculinities in space and time. Africanist perspectives

on the multiplicity of masculinities (Lindsay & Miescher, 2003) and the concept of emergent masculinities (Inhorn & Wentzell, 2011) are alternative theories that account for local context dynamics and change in men's lives. I use these two perspectives to explore the daily social discourse of young Ghanaian fathers.

2.2.2 Multiple African masculinities

Postcolonial African scholars have argued that multiple masculinities and femininities can co-exist in a given context (Dery & Ganle, 2020; Lindsay & Miescher, 2003, p. 4; McKittrick, 2003; Mfecane, 2018; Ratele, 2014). Africanist scholars have demonstrated that African gender orders constitute a "patchwork of patriarchies", some locally derived while others have been established through colonialism (Lindsay & Miescher, 2003, p. 2). They discard the notion that one form of masculinity can dominate other forms and instead show that masculinities can be both dominant and subordinate at the same time, because they have evolved in a complex interface of political, economic, socio-biographic and capitalist hegemonies (Dery, 2019; Dery & Ganle, 2020; Lindsay & Miescher, 2003; Ratele, 2014, 2015). There are several historical examples from various African contexts that illustrate the co-existence of multiple masculinities (Cornwall, 2003; Hodgson, 2003; McKittrick, 2003; Miescher, 2005).

Stephan Miescher's (2005) research on precolonial and colonial masculinities among the Kwahu, an Akan group in Ghana, demonstrated the co-existence of three masculinities. These three are categorised as adult masculinity, senior masculinity, and the big man status. Boys accomplished adult masculinity when they married and provided financial income for their nuclear families and kin. Senior masculinity was assessed based on eloquence, wisdom in arbitrating conflicts, and upholding good social behaviour (such as not getting drunk in public). During the period of colonial rule, senior masculinity became symbolised by educated and salaried men who contributed to the development of their native communities in addition to

exuding eloquence, wisdom and good social behaviour (Miescher, 2007). The big man status was epitomised by men who displayed wealth, polygamy, had many children and supported many people in the community (see also Obeng, 2003). According to Miescher (2003, 2005, 2007), these three persisted concurrently without one gaining dominance over the others.

Contemporary African studies likewise indicate that what is hegemonic cannot be readily discovered from the multiple versions of masculinities available in Sub-Saharan African contexts (Dery, 2019; Dery & Ganle, 2020; Ratele, 2014; Ratele, 2017). Kupano Ratele (2014, p. 31; 2017) has advocated for what he calls "hegemony within marginality", contending that it is impossible to identify an African masculinity that occupies symbolic dominance. For example, economic uncertainties in Sub-Saharan African cities situate young men in positions in which they are sometimes unable to embody culturally-preferred manhood norms (Ratele, 2014). In lieu of such symbolic masculine norms, young African men have been found to express ambivalence, and to critique and protest so-called venerated masculinities (Dery, 2019; Dery & Ganle, 2020; Enria, 2016; Esson et al., 2021). Africanist scholars of masculinities suggest that African men should be studied within their socio-economic positions without attempting to outline an overarching dominant masculinity (Ratele, 2014, p. 39). From a postcolonial perspective, this thesis explores the possibility of multiple co-existing masculinities contouring the lives of young Ghanaian fathers.

2.2.3 Emergent masculinities

Marcia Inhorn and Emily Wentzell (2011, p. 803) have developed a framework called "emergent masculinities" to theorise masculine identities that are not constructed on dominance but rather configured from new meanings, new values and new practices that are constantly being created as men navigate through their life course. The concept draws on R.W. Williams' (1977) concept of *emergence* and Raewyn Connell's concept of *masculinities*. By "emergent",

Williams (1977, p. 123) meant that "new meanings and values, new practices, new relationships and kinds of relationships are continually being created" in societies in a manner that is not stringently opposed to the dominant culture. Inhorn and Wentzell (2011, p. 803) appropriated "emergent" to illuminate "all that is new and changing in the practices of masculinity" while still not necessarily being dominant or opposed to other masculine symbols.

Inhorn and Wentzell (2011, p. 805), through their comparative ethnographic studies in the Middle East and Latin America, illustrated that masculinity is transforming rapidly and generating an urgent need to conceptualise masculinities broadly so as to encompass the complexities and dynamism of contemporary gender practice. Although stereotypical masculine ideals such as "machismo" in Latin America and the four Ps (polygyny, patrilineality, patriarchy and patrilocality) in the Middle East are present, men's lived experiences are far removed from these 'hegemonic' symbols (Inhorn & Wentzell, 2011, p. 805). The authors contended that men are engaged in self-reflections and continually express the desire to elude stereotypical masculine norms (Inhorn & Wentzell, 2011; Wentzell & Inhorn, 2014). In the contemporary rapidly globalising world, men's lives are increasingly defined by their contributions to the family, romantic love, and collaboration, which are more consistent with egalitarian household arrangements than pernicious patriarchal ideals (Hirsch, 2008; Inhorn & Wentzell, 2011; Wentzell & Inhorn, 2014, pp. 693-694). The authors further explained emergent masculinities as the expectation to practice "companionate responsibility", which comprises breadwinning, fidelity, intimacy and care in intimate relationships (Wentzell, 2017; Wentzell & Inhorn, 2014, p. 694).

Many social, political, and structural changes including migration, low fertility rates, new technologies, global capitalist economies and changing family situations imply new configurations of gender practice and negotiations between intimate partners (Cornwall, 2016; Inhorn, 2012, p. 31; Inhorn et al., 2015, p. 6; McLean, 2021; Wentzell & Inhorn, 2014). Studies

on men's lives must account for these changes "physically, socially and over the male life course, over generations, and over the course of social history" (Inhorn et al., 2015, p. 7). This analogy of emergent masculinities corresponds with Africanist scholars' arguments that men's lives are located in manifold shifting political and economic situations that breed multiple and hybridised gender relations (Dery, 2019, 2020; Dery & Ganle, 2020; Ratele, 2014).

Emergent masculinities and Africanists' perspectives seem appropriate to use for capturing the everyday lived trajectories of young Ghanaian men as they become fathers, practice fatherhood, and embody manhood acts. Considering the fragility of what is hegemonic (Dery, 2019, 2020; Dery & Ganle, 2020; Esson et al., 2021), emergent masculinities can elevate our understanding of how these men navigate multiple versions of masculinity. Dery (2019, p. 191) has identified a number of ideals that include heteronormative marriage, fatherhood, financial provider, physical strength, and independence (among others) that young men in Ghana draw from, depending on their locatedness. Masculinities that uphold the breadwinner ideal but do not necessarily bolster the subordination of women have been increasingly found in Ghana and many parts of Africa (Chikovore et al., 2014; Dery & Akurugu, 2021; McLean, 2021; Smith, 2015, 2020). Following this understanding of masculinities in Africa, this study adopts emergent masculinities to theorise change and continuities in existing masculine norms in Ghana. Current expectations of becoming and being a father are analysed to explore the extent to which men do and undo masculinities in the home and at the maternity clinics during their partner's pregnancy.

2.2 Doing gender

Candace West and Don Zimmerman's 'doing gender' theory analyses gender as a product of social doings that are recurrent through interaction with others (1987, p. 129). West and Zimmerman (1987) began their discussion by distinguishing the ideas of sex, sex category, and

gender. Sex is a socially accepted biological criterion for categorising people as females or males (West & Zimmerman, 1987, p. 127). In contrast, sex category is determined by "socially required identificatory displays", including but not limited to clothing, hairstyle, and other sex appropriate indicators and behaviours (West & Zimmerman, 1987, p. 127). In this line of explanation, gender is understood as the process of enacting practices, behaviours and attitudes that are appropriate for one's sex category (Ridgeway & Correll, 2000; West & Zimmerman, 1987, p. 127). Hence, gender is not a role, something individuals are, or a set of features but something that people are expected to achieve and to which they are held accountable (Fenstermaker et al., 2002; West & Zimmerman, 1987, p. 129). West and Zimmerman (1987) elaborated that people do gender in space and time such that when societies transform, situations will demand that practices and interactions are adjusted accordingly. Nonetheless, actions and interactions are constantly subject to accountability, that is, they should be socially comprehended as compatible with the assigned sex category within a given local context (Butler, 2004; Hollander, 2018). Doing gender is inevitable because individuals are oriented around the idea that others will judge them for (perceived) aberrations (West & Zimmerman, 1987).

The 'doing gender' framework, at the time when it was formulated, presented an alternative to both socialisation and structuralist theories by showing that gender difference and inequality are constantly negotiated through social interaction and are malleable in time and space (Deutsch, 2007; Messerschmidt, 2009; Risman, 2018). The idea of 'doing gender' or 'doing genders' (Risman, 2018) has contributed to theorisations of both multiple masculinities (Connell, 2005) and multiple femininities (Schippers, 2007) that are constructed according to contexts. The concept has nonetheless been criticised for its use by researchers to explain

gender difference(s) rather than show patterns of transformation in social interactions (Deutsch, 2007; Messerschmidt, 2009; Risman, 2009, 2018).

Barbara Risman (2009, p. 82) has noted that the 'doing gender' theory accords a binary distinction of women and men's spheres, which works against the intended feminist agenda of promoting gender equality. For example, in research about marriage and power relations between couples, researchers have often interpreted 'doing gender' simplistically as women doing household labour and men doing breadwinning and leading their families (for examples of research see Halleröd, 2005; Heather et al., 2005). Risman (2009, 2018) contended that as societies change and transform, new kinds of gender-appropriate behaviours may evolve, and during this time of change, people will enact gender-inappropriate behaviours. However, Risman observed that when researchers find unexpected behaviours, they have tended to categorise them as new ways of 'doing gender' instead of questioning whether gender is being undone (Risman, 2009, 2018). She posed the question, "why label new behaviours adopted by a group of boys or girls as alternative masculinities and alternative femininities simply because the group itself is composed of biological males or females (Risman, 2009, p. 82)?" Labelling anything that boys/men do as a form of masculinity and anything that girls/women do as a form of femininity, reifies differences and undermines similarities between the sexes (Adams, 2018; McDonald, 2013, p. 565; Risman, 2009, 2018). Studies concerning gender relations should document 'doing gender' and equally acknowledge when gender is undone, rather than saying that a new masculinity or femininity has been found (Risman, 2009; Risman & Davis, 2013, p. 741).

Francine Deutsch (2007) alerted researchers that the terminology 'doing' was responsible for the misappropriation of the theory. She asserted that 'doing' is an excellent word to show that gender is continually configured in recurrent social interactions (Deutsch, 2007, p. 122). Thus,

‘doing gender’ implies both doing acts that conform to one’s sex category and doing acts that are inappropriate to one’s sex category (Deutsch, 2007, p. 123). However, ‘doing gender’ has been misunderstood to mean only conformity, thereby making acts of resistance and opposition invisible (Deutsch, 2007, p. 123). She argued that gender can be undone through repeated social interactions in which both men and women participate as equally competent, which undergirds an optimism of deconstructing the gender system (see also Ridgeway & Correll, 2000; Schippers, 2007).

Deutsch (2007) encourages researchers to generate discussions about how to dismantle the gender system and make the pursuance of equality more pivotal in gender discourses. She highlights five areas that researchers should focus on in the analysis of ‘undoing gender’, namely “when and how social interactions become less gendered; whether gender can be irrelevant in interaction; whether gendered interactions always underwrite inequality; how the institutional and interactional levels work together to produce change; and finally, interaction as the site of change” (Deutsch, 2007, p. 106). These questions raised by Deutsch, particularly, *when and how social interactions become less gendered,* are relevant for studying male involvement in the care for pregnant partners, along with notions of masculinity and fatherhood.

In this study, the ‘doing gender’ framework is first presented to illuminate the local normative constructions of gender in household relations in order to explore whether domestic work has remained a yardstick for gender accomplishment (Davis & Greenstein, 2013; Sullivan, 2018; Treas & Lui, 2013). The framework is then used to explore when and what interactions have become or are becoming less gendered and to examine whether these shifts are new ways of doing masculinities and femininities or acts of ‘undoing gender’ (Adams, 2018; Deutsch, 2007; Risman, 2009, 2018; Risman & Davis, 2013; Sullivan, 2018).

2.3 Space, place and gender

Feminist geographers Doreen Massey and Linda McDowell have discussed space in terms of the manifold social relations encompassing all spatial scales – within households, towns, settlements, workplaces – i.e., from local to global places (Massey, 1994, p. 4; McDowell, 1999). Local, national and global institutions such as the family, school, and media (among others) frame the social formations that construct spaces (Hearn et al., 2014; Massey, 1994, p. 4; Rezeanu, 2015). Places are defined as particular intersecting points where social relations are carried out, configured, protested, and reconfigured (Massey, 1994, p. 5). The social construction of spaces is fluid, interrelating political, economic, gendered and social practices (Massey, 1994; Thiel & Stasik, 2016). People create notable identities and features of a shared place through the navigation of social interactions (McDowell, 1997b, p. 2). These interactions and practices acted at places evolve from cultural and historical positions related to age, gender, class and other social markers (Hearn et al., 2014, p. 31; Massey, 1994; McDowell, 1999).

Gender, as a set of social practices with symbolic meaning, is a significant marker and product of places (Massey, 1994; McDowell, 1999, p. 7). How people 'do gender', what masculine features they display and what feminine features they display at places are parallel to what they expect a man and woman to be within that historical and cultural context (McDowell, 1999). Gendered signifiers of spaces are co-constructed through the recursive conduct of men and women, encounters, and multi-layered understanding of the space and place.

Massey (1994) has noted that both places and spaces are not totally porous nor isolated but subject to change through time and influences of interactions from other places. What may appear to be a simple local place stretches beyond the immediate locality to more comprehensive local, national and global places, with consequences for how social practices unfold (Hearn et al., 2014, pp. 31-32; Massey, 1994, p. 120). Similarly, McDowell (1997b, p. 2) emphasised that places can be 'undone', and that the set of social practices at places like the

home, community and nation can break down and be reconstructed. For example, the large movement of women into waged labour destabilised the assumption that a woman's place is the home and questioned the breadwinner role of men (McDowell, 1997a, 1997b).

The space and place that this study illuminates is the maternity clinic, which can be viewed as a significant 'third place' (Oldenburg & Brissett, 1982) for expectant mothers. Ramon Oldenburg and Dennis Brissett (1982, p. 269) accentuated that third places encompass places outside the home and work place "where people gather *primarily* to enjoy each other's company." Jeffres and colleagues (2009, p. 335) summarised third places "as unique public spaces for social interaction, providing a context for sociability, spontaneity, community building and emotional expressiveness." Third places can include beauty salons, cocktail lounges, pubs, barbershops, child day care centres, gyms, sites of worship, and other public places open for leisure and relaxation (Finlay et al., 2019). These places may operate as physical establishments, but as third places, they provide a plethora of advantages to individuals. Third places promote formal and informal socialization and entertainment, foster a sense of community belonging, and imbue perceptions of security, confidence and comfort as well as encourage social connection and networks (Finlay et al., 2019, p. 2).

Access to third places is recognised as a relevant social determinant of health that stimulates, supports, protects and promotes the mental health of participants (Finlay et al., 2019; Jeffres et al., 2009; Oldenburg & Brissett, 1982; Palmer et al., 2019). Maternity clinics may not be a typical example of third places available to the public or for leisure or relaxation. Nonetheless, for expectant mothers, maternity clinics are physical locations outside the home and workplace that facilitate social support and connection for women during the time of pregnancy. I would thus argue that they could be categorised as a third place.

The maternity clinic, in addition to being a third place, has acquired a gendered signification through women's repeated interaction and use of the place (Massey, 1994). Following feminist geographers' analyses of space, place and gender, I explore the maternity clinic as a 'feminine space' and analyse how masculinities manifest in this 'feminine third place'. Separately, Massey and McDowell (Massey, 1994; McDowell, 1997b) have contended that spaces and places can change over time according to interactions, practices and policies that define these spaces and places. In this light, I analyse how this 'feminine third place' could be reconstructed to include expectant fathers. Finally, I discuss the possible negative implications of deconstructing the maternity clinic (which including men in antenatal care would at least partially imply) for women's access to care and the ability to make decisions about their own health.

3 Literature Review

This chapter presents an overview of the extant literature on three topic areas included in this study. These three topic areas are transformations in household gender practices, norms of fatherhood and norms of masculinity, and men's involvement in sexual and reproductive health matters. The literature summarised here has been searched for and reviewed at various stages of my studies. I searched for articles during the conception of the study, while writing the peer-reviewed articles, and in preparing this thesis. The searches were conducted from Google Scholar and two key databases accessible through the University of Bergen Library search engine, that is, ProQuest Research Database and Social Sciences Citation Index. I used a number of combined terms[1] and sorted articles for their relevance to the topics under study by reading through the abstracts and sometimes the discussion sections. In addition, I read some of the references in the published works that I had already selected to be part of the literature review.

The chapter begins with examples of literature from North America, Australia, UK and Europe loosely classified as 'Western studies' on the gendered division of household labour and involved fatherhood norms. Although these Western studies contained geographically and culturally different empirical materials than my study, they are important for the comprehension of the 'doing gender' framework, and the notions of involved fatherhood discussed in Articles III and I respectively.

I will then outline relevant debates on fatherhood and masculine norms in Sub-Saharan Africa, with a particular focus on Ghana. This stock of literature is particularly relevant to the theories on masculinities, becoming and being fathers and modifications of gender norms and practices

[1] Search terms included: Involved fatherhood Africa; Involved fatherhood Ghana; Masculinities and manhood expectations Africa; Masculinities and manhood expectations Ghana; Doing gender Africa; Doing gender Ghana; and Gender, space and maternity care, Africa; Gender, space and maternity care, Ghana; Male involvement in maternal health Africa; Male involvement in maternal health Ghana.

discussed in Articles I and III. Literature on men's participation in reproductive health, especially antenatal care (ANC) services in Sub-Saharan Africa and Ghana (Article II) are additionally reviewed.

3.1 Western studies on household gender relations

Following the drastic increase in women's participation in waged labour outside the home in the 1970s and 1980s, many studies have been conducted to analyse changes and continuities in the division of household labour (Bianchi et al., 2000; Bianchi et al., 2012; Cabrera et al., 2000; Coltrane, 2000; Davis & Greenstein, 2013; Dempsey & Hewitt, 2012; Goldscheider et al., 2015). Coltrane (2000) in his review of over 200 studies published between 1989 and 1999 on household labour in North America identified three common expositions for the observed transformations in the gendered division of household labour. These explanations come from economic perspectives, from gender perspectives (like the 'doing gender' approach), and from arguments that suggest a complex interplay of individual practices, social expectations and institutional norms (Coltrane, 2000; Doucet, 2013).

According to the economic arguments, men's increased performance of domestic chores emerged out of necessity following the increased involvement of women in paid labour (Acosta & Salcedo, 2018; Bianchi et al., 2000; Bianchi et al., 2012; Bittman et al., 2003; Bünning, 2020; Croft et al., 2014; Goldscheider et al., 2015; Kan, 2008). Bianchi and colleagues (2000) in their study of the allocation of housework among adults in America showed that men increased the amount of domestic work they did when household maintenance decreased due to women's work outside the home. The authors further indicated that men's increased participation in housework evolved within a context where it was becoming expected of men to show competence in doing housework (Bianchi et al., 2000, p. 219).

According to the gender perspectives, doing housework is more about showing competencies for the sex category 'female' than about rational choice decisions (as proffered by the economic models) (Bittman et al., 2003; Coltrane, 2000; Doucet, 2013; Fenstermaker et al., 2002; Halleröd, 2005; Heather et al., 2005; Simister, 2013). In their article entitled "When does gender trump money?", Bittman and colleagues (2003), utilising data from the USA and Australia, demonstrated that women's decrease in housework did not necessarily mean that men increased their time on housework; instead, it meant that families outsourced domestic work. The study contended that gender was a more powerful element in the distribution of household labour than women's participation in paid labour. Indeed, the authors even found what they described as "gender deviance neutralisation", which was that women performed *more* housework as their earnings increased above the income of their partners, to emphasise their femininity and protect their partner's masculinity (Bittman et al., 2003, p. 206; see also Simister, 2013).

Recently, Mandel and Lazarus (2021) used the gender perspective in a study of 25 countries across America, Europe and Asia, and had more encouraging results, showing that local gender ideologies had become the bulwark of the division of household labour by the year 2012. Nations with highly egalitarian gendered ideologies had a parallel increase in male performance of housework (Mandel & Lazarus, 2021, p. 216). This correspondence did not necessarily occur in individual households, but could be discerned as a trend related to country-specific social policies (as will be enunciated in the next paragraph).

In addition to the economic and gender perspectives, scholars have argued that change in the gendered division of household labour can occur through a complex interplay of individual and institutional factors that frame who performs the bulk of housework (Adams, 2018; Coltrane, 2000; Doucet, 2013; Rehel, 2014; Sullivan, 2004, 2018). An example of this discussion is Adam's (2018) analysis of how institutional norms influence gender equality in individual families. She accentuated that the Nordic social policies encourage more men to endeavour to

do housework (Adams, 2018, p. 360). The significance of institutional frameworks has been further demonstrated in the development and expansion of 'involved' or 'new' fatherhood norms.

Involved fatherhood norms and practices developed in the 1980s along with the shifts towards women's increased participation in waged labour (Wall & Arnold, 2007). New or involved fathers are defined as men who, in addition to providing for their families, are emotionally and physically involved in childcare – that is, they play with, hug, cuddle, and give hands-on care to their children (Lutz, 2018; Macht, 2020; Magaraggia, 2012; Wall & Arnold, 2007, p. 510). McGill (2014), drawing on cross-sectional data of children living in two-parent households in the USA, showed that fathers with non-conventional gender attitudes were more likely to adopt norms of involved fatherhood. However, irrespective of men's views on parenting, unemployed fathers spent more time with their children than employed fathers (McGill, 2014).

The availability and use of paternity leave has been argued to promote long-term caregiving practices among men irrespective of their employment status (Rehel, 2014, p. 127). Using semistructured interviews with fathers from three states in the USA, a study has indicated that fathers who took paternity leave developed a similar sense of responsibility as mothers through hands-on experience, and they subsequently carried out parenting activities in a way more commonly associated with mothers (Rehel, 2014, p. 127).

The Nordic region has extensive literature on norms and practices of involved fatherhood (Bach, 2017; Björk, 2018; Björk, 2013; Bloksgaard et al., 2015; Eriksson & Hajdu, 2021; Eydal & Rostgaard, 2018; Farstad & Stefansen, 2015; Miguel et al., 2019). A study of Icelandic fathers of young children indicated that men across social classes adopted involved fathering norms in a complex picture (Farstad & Stefansen, 2015). The study showed that fathering practices of middle-class men aligned with the Nordic fathering policies, while working-class

men were more likely to take a secondary role to women in caring for small children. The authors argued that family-friendly policies in Nordic regimes facilitate the construction of varying forms of involved fatherhood and masculinities that are suitable for transformative gender relations (Farstad & Stefansen, 2015, p. 67; see also Haukanes & Heggli, 2016, p. 176).

Although many studies have cited Nordic social policies and argued that these are bedrocks of more egalitarian household arrangements, some studies have illustrated that male performance of domestic and care work is still not ubiquitous (Halvorsen & Ljunggren, 2020; Sevón, 2011). A study from Finland showed that new mothers were often disappointed by their partners' lack of participation in parenting new-borns (Sevón, 2011). In Norway, a recent study highlighted the tendency of young men to enact conventional views of male dominance and female subordination in their daily lives, although they shared the national discourse of gender equality in self-conscious discussions (Halvorsen & Ljunggren, 2020, p. 14). These examples from the Nordic context, the distinguished hub of gender equality discourses, signal the complexities of gender ideologies in the domestic arena.

3.2 Fatherhood and the construction of masculinities in Sub-Saharan African contexts

Scholarship on fatherhood and masculinities in Sub-Saharan Africa has grown tremendously over the last decade, especially from South Africa and now increasingly from other parts of Africa. In this section, I attempt to present an overview of studies from Sub-Saharan Africa, mainly South Africa, before focusing on studies from Ghana.

Sub-Saharan African imaginaries of fatherhood have to a large extent been characterised by the image of the stereotypical patriarch who provides for his family and children but is detached from physical and emotional care and does not participate in 'feminine' domestic spaces (Rabie et al., 2020, p. 460). Scholars have argued that this image, which suggests that African fathers are uninvolved in their children's care and development, is misleading (Rabie et al., 2020).

Fatherhood and parenting in many Sub-Saharan African contexts were conceived of as a communal responsibility, where men offered paternal affection and guidance to both biological and non-biological children (Dery & Bawa, 2019; Makusha & Richter, 2014; Rabie et al., 2020; Ratele et al., 2012). In some precolonial African contexts, fathers and men in general were not assumed to be breadwinners; rather, they represented their kin in communal matters and trained boys in the family to become adults (Chikovore et al., 2013, p. 264; Lindsay, 2007; Miescher, 2005; Silberschmidt, 2001). As discussed in the introduction, fatherhood norms in Sub-Saharan African contexts have become hybridised by colonialism and urbanisation with a central connection to the provider role within families (Allman, 1997; Chikovore et al., 2013, p. 263; Makusha & Richter, 2014; Miescher, 2005).

Within this hybridised frame of fatherhood, the literature in the last decade has indicated that the arena of becoming and being a biological father has expanded to include images that correspond with western notions of involved fatherhood (Ejuu, 2016; Makusha & Richter, 2014; Smith, 2015). Research has shown that men are willing to give hands-on care to their children although they are sometimes constrained by cultural norms, poverty, and social policies (Ejuu, 2016; Jorosi-Tshiamo et al., 2013; Makusha & Richter, 2014; Rabie et al., 2020). Men who become physically involved in giving hands-on care to their children have been found to construct masculinities that do not commend violence and physical strength (Morrell et al., 2016; Morrell & Jewkes, 2011; Sikweyiya et al., 2017).

Morrell and Jewkes' (2011, p. 6) study of the nexus between care work and gender equality among young South African men suggested that men who performed domestic work did not see caring as "unmasculine". The study indicated that some men embraced a commitment to gender equality in giving care to their children, while others viewed caregiving as a continuation of providing for and protecting their nuclear families, which is consistent with patriarchal masculinity (Morrell & Jewkes, 2011, p. 7). Another South African study found that men who

experienced positive parenting as children and were more open to gender equality were more likely to be involved in doing housework and giving care to their children (Morrell et al., 2016). The study moreover observed that men sometimes performed house and care work out of necessity and as a compensation for their inability to provide the family's income (Morrell et al., 2016, p. 98). Other South African studies have highlighted that young fathers are increasingly becoming more interested in providing for their children and being physically present in the household than engaging in behaviours such as alcohol abuse or physical violence that are perceived as irresponsible fatherhood (Chili & Maharaj, 2015; Enderstein & Boonzaier, 2015; Hosegood et al., 2016).

Scholarship from other Sub-Saharan African contexts has illustrated shifts towards masculinities that uphold men's roles as leaders of their families and simultaneously propagate equal partnership in intimate relationships and norms of involved fatherhood (Groes-Green, 2012; McLean, 2021; Smith, 2015; 2020, p. 112). A study conducted in Mozambique demonstrated that masculinities that reject gender hierarchies, but accept female autonomy and equal tasks and decision-making among boys and girls, have appeared and exist alongside misogynist ideals (Groes-Green, 2012). A study from Nigeria showed that shifts in divisions of household labour among intimate partners reflected more egalitarian arrangements in conjunction with the construction of more intimate parenting roles for men (Smith, 2015, p. 329). Hence, men who share housework with their partners are more likely to be committed to sharing decision-making in domestic arenas and to practice involved fatherhood norms (Smith, 2015). The growing espousal of emergent masculinities has also been demonstrated in post-conflict Sierra Leone (McLean, 2020, 2021). Men in Sierra Leone embodied emergent masculinities by providing for their family, engaging in housework, practising companionate marriages, and showing love and compassion for others (McLean, 2020, 2021).

At the same time, other studies have indicated patterns of division of household labour that destabilise the male-breadwinner ideal while still upholding the female-domestic caregiver notion (Evans, 2016; Ilomo et al., 2021). Evans (2016) showed that men in Zambia were constrained by normative gender perceptions of others in their households and community, which prevented them from carrying out house and care work even when they wanted to do so. In Tanzania, Ilomo and colleagues (2021) indicated that it is easier for men to 'undo gender' in the marketplaces (that is, to engage in trading activities viewed as 'feminine') and participate in organisations with female leaders than it is for them to perform household chores.

Extant studies on masculine norms in Ghana have emphasised biological fatherhood, strength, power, authority, leadership, breadwinning and non-performance of housework as expected manhood embodiments (Adomako Ampofo & Boateng, 2007; Adomako Ampofo et al., 2009; Fiaveh et al., 2015; Lambrecht, 2016; Nukunya, 2016; Obeng-Hinneh & Kpoor, 2022; Owusu & Bosiwah, 2015). In their study of adult males in Accra, Adomako Ampofo and colleagues (2009) found that masculinity was intricately encircled by biological fatherhood, having a wife, and providing for the nuclear family (see also Miescher, 2003, 2005, 2007; Owusu & Bosiwah, 2015). Biological fatherhood is particularly important for the continuation of the family lineage, which is described as a necessary male responsibility (Owusu & Bosiwah, 2015; Tabong & Adongo, 2013).

Ghanaian masculinities are also configured around the performance of household chores (Adomako Ampofo & Boateng, 2007). A study of boys between 11 and 15 years old found that transitioning from boyhood to manhood meant a cessation of housework because domestic duties were identified as 'feminine' (Adomako Ampofo & Boateng, 2007). Men performed housework when they were single, but upon marriage, this work was expected to be transferred to wives as their culturally-expected responsibility. Marriage is therefore a significant site for constructing masculinity and a context with vast male privileges of exercising control over

women, which has been arguably linked to gender-based violence (Adinkrah, 2012, 2017; Adjei, 2016; Dery, 2021; Sikweyiya et al., 2020). At the same time, some participants in Adomako Ampofo and Boateng's (2007) study did not see marriage as a site for overstretched male privilege and exercise of relentless domination over women. Some participants were against gender-based violence and said that they would have to share housework with their wives, while others said a responsible man would 'help' his wife with housework. Adomako Ampofo and Boateng (2007, p. 59) asserted that such alternative views of manhood inform the nurturing of masculinities that are not founded on the subordination of women.

Other studies have described the disruption of culturally-favoured gendered expectations in Ghanaian households (Arnot et al., 2012; Boni, 2002; Clark, 1999; Dery et al., 2019; Ganle, 2015; Kwansa, 2012). A study by Kwansa (2012) conducted ten years ago showed that working fathers in Accra performed household chores and gave hands-on care to their children. Wallace and Adongo's (2018) ethnographic study of men's perceptions of family planning in a rural Ghanaian setting revealed that polygamy was becoming less common while spousal communication and love were increasingly emphasised as popular elements of young couples' relationships. The fall of polygamy and increased spousal communication, they argued, demonstrates a modification of intimate relationships towards companionate marriages (Wallace & Adongo, 2018, p. 143). The presence of companionate marriages could imply more equal sharing of parenting and housework among intimate partners as has been observed in Sierra Leone and Nigeria (McLean, 2021; Smith, 2015).

More recent evidence from a similar rural setting has indicated the existence of multiple masculinities and men's adoption of more than one ideal of culturally-valued masculinity (Dery & Akurugu, 2021). A study conducted by Dery and Akurugu (2021, p. 186) found that hegemonic masculinity manifested among participants as breadwinning, although participants' narratives suggested examples of 'undoing gender' among educated and employed study

participants. For example, some participants expressed an interest in performing domestic duties like cooking to support their families. Dery and Akurugu (2021) concluded that even in contexts where the gendered division of household labour appeared rigidly structured and in line with local cultural norms, examples of masculinities that promote gender-equal practices could be found.

In sum, many of these studies on masculine and fatherhood norms in Sub-Saharan Africa have shown a trend of expanding parenting roles for men, including norms of involved fatherhood in conjunction with the enactment of manhood acts that do not reinforce gender inequality. In the next section, I seek to outline core debates articulated in studies conducted on the topic of including men in reproductive health matters.

3.3 Men's involvement in reproductive health matters in Sub-Saharan Africa

This section will present an overview of research conducted on men's inclusion in sexual and reproductive health matters in Sub-Saharan Africa. The studies delineated here are formulated around three topic areas relevant to this dissertation. The first topic area focuses on studies that discuss personal challenges of men that hinder their active participation in maternal health services. The second topic area focuses on studies that have explored strategies to include men in maternity care services. The third topic area shows how involving men in reproductive health matters can dis/empower women.

A number of studies have identified that gender norms, which define pregnancy as the responsibility of women and limit men's roles to breadwinning, is one of the core barriers to men's active participation in maternity care services (Aborigo et al., 2018; Agyare et al., 2018; Gibore & Bali, 2020; Gibore et al., 2019; Manda-Taylor et al., 2017). Other studies have explored interpersonal challenges that hinder men's participation in maternity care services. These challenges include men's lack of knowledge about the benefits of their involvement, long

waiting hours at the clinic, shyness in participating in a space where women outnumber men, and the fear of being tested for HIV (Craymah et al., 2017; Ganle & Dery, 2015; Kabanga et al., 2019; Njunga & Blystad, 2010; Quarcoo & Tarkang, 2019). The literature has moreover discussed how the attitudes of health workers towards expectant couples, the limited physical space at health facilities, and the absence of messages tailored for male partners all hinder men's attendance at maternal health services (Galle et al., 2019; Ganle & Dery, 2015; Gibore & Bali, 2020; Påfs et al., 2016).

A score of research has been dedicated to identifying strategies that can enhance men's active participation in maternal health services (Gill et al., 2017; Kululanga et al., 2011; Maluka et al., 2020; Mwije & Holvoet, 2021; Nkwonta & Messias, 2019; Peneza & Maluka, 2018). Interventions that focus on community mobilisation and educational campaigns have been indicated as being sustainable options. Kululanga and colleagues (2011) in Malawi, and Gill and colleagues (2017) in the Democratic Republic of Congo, found community mobilisation and campaigns about safe motherhood, peer-to-peer counselling, and couple invitation letters to be effective strategies. Maluka and colleagues (2020) recommended approaches that bring men and women together to jointly diagnose, design and implement culturally acceptable initiatives that augment male participation in maternal healthcare. Studies from Ghana have similarly identified the engagement of community leaders in educational campaigns as effective long-term solutions to male involvement in maternal health services (Aborigo et al., 2018; Ganle & Dery, 2015).

Male involvement initiatives built on incentives (carrots), such as gifts and quicker access to services for male attendees, and coercion (sticks), such as denying unaccompanied women access to care, have been identified as untenable and less empowering for expectant mothers (Kululanga et al., 2011; Manda-Taylor et al., 2017; Mwije & Holvoet, 2021, p. 149; Osaki et al., 2021; Peneza & Maluka, 2018). In a study based in Tanzania, Peneza and Maluka (2018)

showed that initiatives like denying mothers access to care when they attend clinics without male partners undermines women's rights. They also argued that fast-track services for women attending services with their partners stigmatises single mothers and mothers whose partners cannot participate in services for various reasons (Peneza & Maluka, 2018, p. 6). A review of initiatives across Uganda found that women sometimes attended a clinic with "fake husbands" in order to access gifts and faster service (Mwije & Holvoet, 2021, p. 149). Moreover, once the expectation of incentivisation had been set, male partners stopped participating when incentives were no longer offered (Mwije & Holvoet, 2021, p. 149). These examples support arguments that the use of incentives in delivering health services has the potential to undermine access to quality healthcare (Chimhutu et al., 2014; Chimhutu et al., 2019).

A dominant argument in the male involvement literature has however been that men understand their roles based on the socio-cultural spaces available to them (Bougangue & Ling, 2017; Dumbaugh et al., 2014; Gibore & Bali, 2020; Matseke, Ruiter, Barylski, et al., 2017; McLean, 2020; Powis, 2020; Påfs et al., 2016). Hence, male non-attendance at maternity clinics should not be (mis)understood as men being uninterested in female reproductive health. In Rwanda, Påfs and colleagues (2016, p. 4) illustrated that men's understanding of their involvement during pregnancy broadly covered norms of an involved father who financially supported the household and gave hands-on care, showed affection, attended ANC and helped with domestic chores. Male non-attendance to ANC alone did not mean their non-involvement in pregnancy (Påfs et al., 2016).

Similarly, Gibore and Bali (2020, p. 11) showed that men in Tanzania were actively involved in arranging transportation to the facility and providing financial and material resources, but preferred that other women in the family accompany pregnant partners for ANC. This preference was related to the customary notion that pregnancy and childcare are women's spheres while men's roles are limited to breadwinning and leadership (Gibore & Bali, 2020;

see also Mkandawire & Hendriks, 2019). A study in Sierra Leone also demonstrated that men see themselves as essential and equal stakeholders in successful pregnancy and birth of their children, and perform various roles of providing material resources and giving women emotional care, affection and encouragement (McLean, 2020, p. 6). These roles are performed with or without men's physical presence at maternity care services (McLean, 2020).

The literature on Ghanaian male involvement has findings similar to those above (Aborigo et al., 2018; Agyare et al., 2018; Bougangue & Ling, 2017; Dumbaugh et al., 2014). For example, Bougangue and Ling (2017, p. 9) found that men were actively involved in their partner's pregnancy by providing money for care and medicine, helping with housework, assisting with adherence to medication and supplements, and to a limited extent, attending maternity care services. Men who said that they could not perform 'feminine' roles like doing housework and accompanying partners to the clinic arranged for female relatives to help their partners during pregnancy (Bougangue & Ling, 2017). Concisely, these findings demonstrate that male involvement in Sub-Saharan Africa is varied, and men are actively involved in the care for their pregnant partners, both physically and emotionally within the culturally available spaces.

Of equally significant interest are the findings that suggest that male participation in reproductive health matters could disempower women at maternity clinics and weaken women's autonomy in pregnancy and childbirth-related care (Dumbaugh et al., 2014; Galle et al., 2019; Ganle et al., 2016; Peneza & Maluka, 2018; Påfs et al., 2016). In the Ghanaian household setting, Dumbaugh and colleagues (2014, p. 7) asserted that the sphere of pregnancy and childbirth is one of the few domains where new mothers and senior women in the family prove their generational knowledge by wielding authority over maternal and childcare practices. Thus, women may be unwilling to relinquish that power to men.

In the health facility context, Ganle and colleagues (2016, p. 200) confirmed that women are eager to protect the maternity clinic as a 'feminine space' to connect with other expectant mothers and discuss reproductive matters without men's interference. The study also indicated that women preferred that men maintain their breadwinning roles and not participate in maternal health services (Ganle et al., 2016, p. 201). Findings from a study in Mozambique demonstrated women's loss of autonomy when men participated in maternal health services (Galle et al., 2019). The authors observed that a male partner and the health worker (either male or female) tended to take leading roles during pregnancy care consultations, making women unable to express thoughts about their health (Galle et al., 2019, p. 11).

Although men's participation in reproductive healthcare and services could be potentially disempowering for women, some studies have shown that gender-transformative programmes formulated directly on men's involvement in pregnancy-related care can nurture new fatherhood and masculine norms (Comrie-Thomson et al., 2019; Doyle et al., 2014; Doyle et al., 2018; Mkandawire & Hendriks, 2018, 2019). In Rwanda, an intervention that educated fathers and their female partners on topics concerning men's participation in sexual and reproductive health, maternal and new born health services, and domestic violence was found to increase gender-equitable attitudes in the household (Doyle et al., 2014; Doyle et al., 2018). Findings from an evaluation of the programme showed that men who participated in the programme more readily performed domestic work, and crucially did not see their role as supporters but as sharing equal responsibilities with their partners (Doyle et al., 2014, p. 528; Doyle et al., 2018).

Similarly, a study conducted in Tanzania and Zimbabwe following a male involvement in pregnancy-related care programme found changes in gendered attitudes (Comrie-Thomson et al., 2019). The findings of the study highlighted that alterations in couples' relationships propelled men to participate in domestic work and give care to their children. The authors

suggested that male involvement interventions should explore love and intimacy among couples since these appeared to be significant in encouraging gender equality in domestic arenas (Comrie-Thomson et al., 2019, p. 734).

3.4 Summary

The literature reviewed in this chapter sheds light on the modifications of gender norms and practices in the household and its extending edges to the construction of new fatherhood and masculine norms in Western and Sub-Saharan African contexts. Gender relations in the household have been influenced by multiple factors including cultural norms, rational economic choices, and public policies. The literature shows the occurrence of multiple gender practices among young men in Sub-Saharan Africa and Ghana. Research on men's inclusion in sexual and reproductive health matters has demonstrated a plethora of features that hinder and/or facilitate men's active participation in maternity services. Additionally, some of these studies have explored men's understanding of their involvement in pregnancy-related care, while others have elucidated the gendered consequences of including men in maternity care services. Drawing on both rural and urban perspectives, the present study attempts to contribute to the analysis of complex norms and practices of fatherhood and masculinity, and investigate how these norms and practices interrelate with men's participation in care for their partners and households during the time of pregnancy in Ghana.

4 Methodology

This chapter provides an account of the methodological choices and decisions made in the conduct of the study. In the sections that follow, I will present the study settings and describe the epistemological assumptions underpinning the study design. Thereafter, I will explain how I gained access to the field and selected study participants, which will be followed by a description of data collection methods and an account of how the data were analysed. The chapter will end with an explanation of the ethical considerations observed in conducting the study.

4.1 Study setting

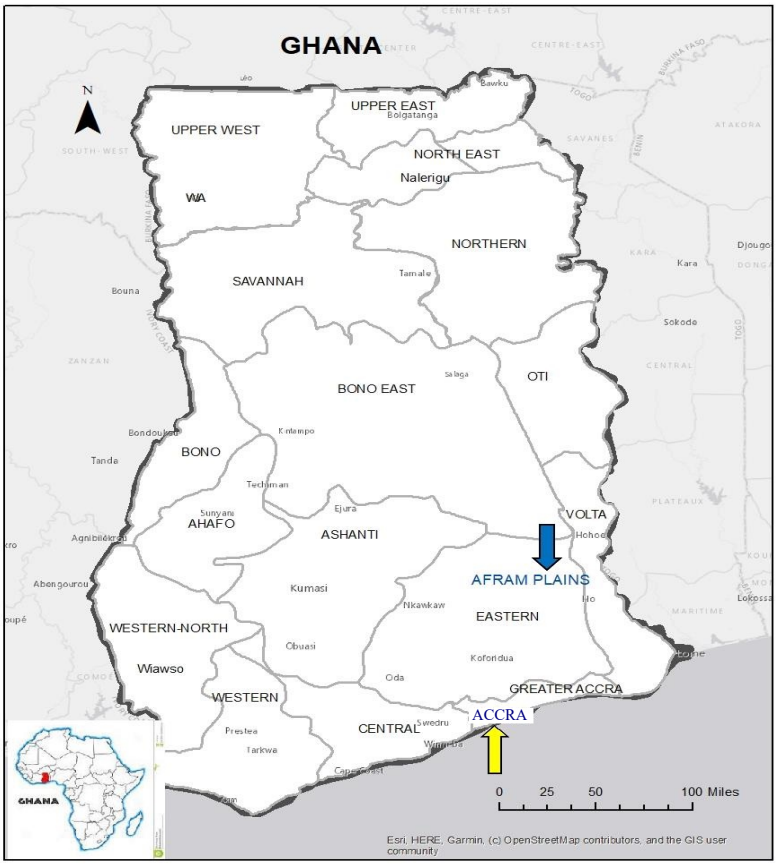
This section sketches a basic demographic overview of Ghana, Accra and Afram Plains. Ghana, a country located in West Africa, was previously a British colony until it became independent in 1957. The provisional findings of the 2020 national population census indicate that Ghana has about 30.8 million residents, 50.7% women and 49.3% men (GSS, 2021a, p. 2). Ghana currently has sixteen administrative regions, namely Greater Accra, Ashanti, Western, Western North, Central, Eastern, Volta, Oti, Ahafo, Bono, Bono East, Northern, North East, Upper East, Upper West and Savanna. There are six primary ethnic groups in Ghana: Akan, Mole Dagbani, Ewe, Ga-Dangme, Gurma and Guan (GSS, 2013a, p. 61).

Accra, Ghana's capital city is part of the Greater Accra Region and is in southern Ghana on the Atlantic Ocean. In 2021, Greater Accra had a population of roughly 5.4 million, with diverse ethnicities from all parts of Ghana (GSS, 2021b). The 2010 census showed that the nuclear family structure had become more common in Accra than the extended family structure. Majority of the population in Accra was either co-habiting, single, widowed or divorced and less than 40% was married (GSS, 2013b, p. 40). The fertility rate in Accra was estimated at 2.5 in the 2010 census (GSS, 2013b, p. 64). To the north of Accra, the Afram Plains North District

has about 100,000 residents, and like Accra, is made up of diverse ethnicities from all regions in Ghana (GSS, 2014, p. 15). The district thrives on farming and fishing and 86% of the population is rural (GSS, 2014, p.15). The general fertility rate in the district as of 2010 was estimated at 4.2 (GSS, 2014, p. 18).

Figure 1. Map of Ghana showing the locations of Accra and Afram Plains

Map prepared by Sheila Akontor and Andy Asamoah Osei, University of Ghana, Legon.



4.2 Epistemological considerations

The study is underpinned by a social constructivist approach to science. Social constructivism maintains that ontology, that is, what is seen as real, is subjective, multiple, and dependent on

the experiences and understanding of the people being studied (Creswell, 2014; Lincoln et al., 2018, p. 113; Neuman, 2014). “Individuals develop subjective meanings of their experiences” in a particular social milieu resulting in the construction of multiple realities (Creswell, 2014, p. 8). Following this school of thought, I embarked on a journey to explore what is real and meaningful to study participants in terms of fatherhood, masculinity and men’s care for their households and partners during pregnancy. I aimed to search for subjective meanings and realities through open-ended interviews and focus group discussions (FGD) that allowed participants to determine what was most meaningful and relevant for them to discuss.

Social constructivism also recognises that knowledge is co-constructed in an interaction between researchers and the researched in a natural setting of the study participants (Carter & Little, 2007, p. 1321; Neuman, 2014; Yilmaz, 2013). Researchers develop a relationship with the researched and become participants in the social processes that they study (Yilmaz, 2013). Based on this understanding, I gathered the data for this study in two settings relevant to the study participants, which was homes/community and maternity clinics, using participant and unobtrusive observation, semistructured interviews and FGDs.

In a social constructivist approach, knowledge is complete upon interpretation, which is based on a combination of the outcomes of the interactions between researchers and the researched and conceptual frameworks relevant to the aims of the study (Carter & Little, 2007; Holstein, 2018; R. Spencer et al., 2014). Although participants provide subjective meanings, researchers are expected to construct whole and complex accounts, albeit while recognising the nuances and interconnections in the narratives (Lincoln et al., 2018, pp. 120-121). To present a complete meta-narrative, I utilised different sociological theories of gender to mesh and pattern participants’ accounts, practices, experiences and reflections.

It is moreover understood that knowledge produced based on social constructivist epistemologies are influenced by a researcher's background, personal biases, and socio-cultural norms (Creswell, 2014; Lincoln et al., 2018; Yilmaz, 2013). Rather than separate themselves from the study and findings, it is required that researchers keep a reflexive account of their interactions with study participants to show the extent to which their background and biases have affected the meanings and interpretations of people's experiences (Carter & Little, 2007; Creswell, 2014; Lincoln et al., 2018). Following this line of thought, I have endeavoured to account for and discuss how my socio-cultural and educational background influenced the knowledge created from this study (Chapter 6).

Studies based on a social constructivist worldview are expected to use research methodologies that are based on an inductive logic, rich descriptions of study contexts and individual experiences, and designs and questions that are adjustable upon encounters with the study setting and participants (Yilmaz, 2013, p. 316). This study draws from phenomenological and ethnographic approaches, both grounded in social constructivism. Below, I describe how these two methodological approaches inspired the research process.

4.3 Combining phenomenological and ethnographic approaches

Qualitative research scholars have acknowledged that the borders between various typologies of qualitative designs are blurred (Denzin & Lincoln, 2018, p. 2; Green & Thorogood, 2018, p. 65). As a consequence, some studies may not fit into clear-cut categories, and researchers are encouraged to embrace qualitative studies in their various forms, including the possibility of studies to manoeuvre between research designs (Denzin & Lincoln, 2018, p. 2; Green & Thorogood, 2018, p. 65). I took this approach in my study, which navigates between phenomenological and ethnographic approaches.

Phenomenological studies are focused on inquiring into the subjective everyday lived experiences and meanings, and attempt to describe the uniqueness of these subjective meanings and experiences, mainly using interviews (Green & Thorogood, 2018, p. 43). However, as Green and Thorogood (2018, p. 43) indicated, many published studies based on phenomenological approaches are focused on experiences of their study participants, rather than delving deeper to delineate the distinctiveness of the experiences and meaning. The present study was conceived with a phenomenological understanding that aimed to decipher the meaning (Creswell, 2014; Green & Thorogood, 2018) in young men's lived experiences of fatherhood and masculinity in contexts when they were expecting a child and after the birth of their child(ren). I expected that men would describe their understanding and lived experiences of becoming and being fathers and their involvement in the care for pregnant women, and that women and health workers would describe their expectations and perceptions of men's roles during pregnancy.

In the process of accessing these 'experiences', 'meanings' and 'understandings', ethnographic methods became central in the present study. Ethnography can be described both as a process and as a product of inquiry (Harrison, 2014, p. 225). In this study, ethnography is understood as a process of data collection with the goal of searching for meaning in social phenomena through sustained interaction with the context (Atkinson & Pugsley, 2005; Harrison, 2014; Markham, 2018, p. 653). I conducted participant and non-participant observations in social milieus (homes/community and health facilities) as well as informal conversations, semistructured interviews, and FGDs (Atkinson & Pugsley, 2005). This approach was useful in interacting with study participants in naturally occurring environments and providing rich descriptions of participants' experiences, practices and reflections.

4.4 Access to the field

The two research sites, Ghana's capital city Accra and a rural community in Afram Plains, were selected to explore urban and rural perspectives on fatherhood, masculinity and men's involvement in care for pregnant women. As part of this broad aim, I wished to explore men's experience of maternal health interventions and/or services from urban and rural areas. Hence, maternity care centres were chosen as vital sites for observation and recruitment of study participants.

4.4.1 Urban research site

I selected a government hospital in Accra as the key site of recruitment for expectant fathers and mothers because its client-base emerged as more typical of the average Ghanaian than private health facilities, whose client-bases are primarily middle to high-income earners. A friend introduced me to the administration of the selected hospital. I gave a copy of the research protocol to the administration of the hospital and the matron of the maternity clinic. The matron of the maternity clinic introduced me to both the antenatal and child welfare clinics to seek their permission to conduct observations and recruit study participants. I distributed information letters about the study to all health workers in the maternity and child welfare clinics.

The selected hospital organised pregnancy schools for expectant couples, which I initially misunderstood as a form of men's involvement in maternal health intervention. I planned to recruit expectant fathers and mothers from the pregnancy school as the core study participants. However, I learned from participating in the school that this service was an extension of antenatal care (ANC) sessions and not a men's involvement initiative. No male partners were present at the pregnancy school during my first participation. In contrast to the pregnancy school, I observed expectant fathers at the maternity and child welfare services, which were organised daily on weekdays. Consequently, I shifted the recruitment site from the pregnancy

school to the maternity and child welfare clinics of the same hospital where I recruited expectant fathers, expectant mothers, mothers with small children and mothers-in-law.

4.4.2 Rural research site

The rural research site was a village in the Afram Plains North District, which I have pseudonymised as Sakora. I aimed for a rural health facility setting with some form of men's involvement in maternal health intervention. PLAN International, Ghana country office was at the time of the fieldwork implementing a project called *Strengthening the Health of Women and Children* (SHOW) in several rural and semi-urban areas in Ghana, and I aimed to conduct the study in one of their programme communities. SHOW was a multi-country programme with a central aim of engaging men in the health of the mother, new-borns, and children, and in sexual and reproductive health (see Promundo-USA & Canada, 2020). I contacted PLAN Ghana country office in Accra and sought permission and assistance to access one of their project communities. PLAN Ghana gave me the chance to choose from a few of their project sites in Southern Ghana and I selected their services at Afram Plains. Afram Plains has many small communities and PLAN Ghana had a few implementing communities and a list of other communities where SHOW was about to be launched. Although my understanding was that I would be introduced to a community where SHOW was ongoing, I was introduced to one that was now about to launch SHOW.

I distributed the research protocol to PLAN Ghana country office in Accra, to the District Health Directorate of Afram Plains North, and to the health workers at the Community-based Health Planning Services (CHPS) compound in Sakora. The district coordinator of PLAN Ghana in the Afram Plains and the midwife in charge of the CHPS compound introduced me to the village chief and elders through a formally arranged gathering. The study was then introduced through a general announcement to the community members.

I was hesitant to conduct the research in a community with no experience of men's involvement intervention because of the uncertainty about whether I would be able to compare urban and rural men's experiences of men's involvement in maternity care services or/and interventions. However, the community elders showed a keen interest in the study after our introductory meeting and immediately began discussing arrangements for my stay. Thus, I decided to stay and explore alternative avenues to learn about how men are involved in the care of their partners and households during the period of pregnancy. I recruited participants from the entire community. Expectant fathers and mothers were identified with the assistance of health workers at the CHPS compound. The midwife and nurses introduced me to expectant mothers in the community. Subsequently, I recruited partners of the expectant mothers and other women in the community.

The consequence of my decision to stay on in the community proposed by PLAN Ghana was that I was unable to explore rural men's experiences of ANC services, hence Article II focused only on men in the Accra study setting. However, the community was very interested in the study, and I was able to generate comprehensive data for the analysis of the co-construction of fatherhood and masculinities (Article I) and shifts in gender relations in the household during pregnancy (Article III).

4.5 Participants

Purposive sampling was adopted to facilitate the recruitment of expectant fathers, mothers and other participants that could share insights on the topics under study. The primary participants of the study were expectant first-time fathers while expectant mothers, mothers with children under one year old, older women (like mothers-in-laws), health workers and other background informants were secondary participants. I saw it as essential that the men interviewed were first-time expectant fathers because I aimed to explore their experiences and practices while waiting

to become fathers, and practices and experiences after becoming fathers. It was additionally important that men who were recruited lived together with their pregnant partners if I was to elucidate gender relations in the households during and after pregnancy. Thus, the inclusion criteria for men were first-time expectant fathers living together with their pregnant partners. The criterion worked well in Accra, except in one case where a father had biological children from a previous relationship, and this background information became known to me only during the interview.

However, in Sakora, the recruitment criterion appeared to be inappropriate since it was common that many first-time expectant fathers were not in a steady relationship and lived separately from their pregnant partners. To find men who were in a steady relationship, I had to recruit men who already had children and were expecting another child during the interview. This change had two implications for the research process. Male participants in Accra talked about their current practices and experiences during the pregnancy period and expected practices and experiences after childbirth. Male participants in Sakora talked about their current practices and experiences during the pregnancy period and their lived experiences of fatherhood. While a few male participants in Accra were interviewed after the birth of their children, I decided not to interview men after childbirth in Sakora since this material had already been covered during the first data collection.

The Accra male participants (11) were between 28 and 39 years old and had educational backgrounds ranging from junior high school to tertiary education. All male participants were expecting a child and lived with their partners in a nuclear family setting. The male participants and their partners worked outside the home, in the informal sector as traders or artisans, or in the formal sector as teachers, sales personnel, or civil-service administrators. In Sakora, male participants (12) were between 21 and 48 years old and had educational backgrounds ranging

from primary school to senior high school. They all worked as farmers, although two men supplemented farming with providing motorcycle transport services.

Expectant mothers, mothers with children under one year old, and older women were the second category of participants. Women were included in this study to learn about their expectations and experiences of men's roles during the time of pregnancy. The inclusion criteria for mothers were that they were expecting a child or already had biological children. Twenty-four women (including seven partners of the male participants) were included from Accra. They were between 18 and 51 years old and had educational backgrounds ranging from junior high school to tertiary education. Most female participants in Accra worked outside the home as traders, artisans, teachers, or administrators, while a few were unemployed. In Sakora, 12 women (including eight partners of the male participants) between 18 and 48 years old with educational backgrounds ranging from the completion of primary school to senior high school, participated in the study. All female participants in Sakora worked as farmers and petty traders.

In both Accra and Sakora, study participants belonged to diverse ethnic groups, that is, Ewe, Akan, Guan, Ga-Dangme, Mole Dagbani, and Hausa. The nuclear family structure was common among both urban and rural participants. The housing pattern found among the Accra participants can be described as three kinds: first, houses with private compounds, private bathrooms, and private kitchens; second, apartments with shared compounds but private bathrooms and private kitchens; and third, apartments with shared compounds, shared bathrooms, and shared kitchens. Couples in Sakora lived in privately owned (small) houses; often the compound would consist of some two to four small separate houses inhabited by nuclear families of the same kin group. Bathrooms and kitchens were separated from the main houses. Sometimes, two or more kin groups shared bathrooms.

Health workers (midwives, a public health nurse, community health nurses (CHNs) and a health volunteer) formed the third category of participants in the study. Health workers were included to explore their roles and experiences of male involvement in maternity care. In Accra, three midwives and six CHNs were engaged in interviews and a focus group discussion (FGD), and in addition there were informal conversations with other health workers. In Sakora, one public health nurse, one midwife, three CHNs and one health volunteer participated in the study. Two other informants who worked at the Afram Plains North District office of the Commission of Human Rights and Administrative Justice (CHRAJ) were included to provide background information.

Table 1. Overview of study participants

Participant	Number	Age range	Educational background
Accra male participants	11	28-39	Senior High School-Tertiary
Accra female participants	24	18-51	Junior High School-Tertiary
Sakora male participants	12	21-48	Primary-Senior High School
Sakora female participants	12	18-48	Primary-Senior High School
Health workers Accra	9	NA	Tertiary
Health workers Sakora	6	NA	Tertiary
Other	2	NA	Tertiary
Total	**76**		

4.6 Data collection

Data collection for this study took place in two phases. The first period was from June to October 2017 when all participants were recruited. I conducted semistructured interviews, focus group discussions (FGDs) and observations in the two settings during this period. The second phase occurred from July to October 2018 in Accra only. More observations were conducted and a few selected participants in Accra were interviewed to gather their post-childbirth experiences. Rural participants were not included in the second phase of data collection since the rural men had already become fathers, and had talked about their experiences of childbirth

and childcare during the first interview. Below, I describe the methods that were used to collect the data during both phases of fieldwork.

4.6.1 Semistructured interviews

The semistructured interview is defined as "an interview with the purpose of obtaining descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena" (Kvale & Brinkmann, 2009, p. 3). Semistructured interviews are described as more concerned with participants' descriptions of their lived experiences than with their general reflections, and are designed to permit following up on angles of the conversation that participants find important (Brinkmann, 2014, 2018). Qualitative research experts argue that semistructured interviews should be conducted with open-ended topic guides that can be adjusted during the research (DiCicco-Bloom & Crabtree, 2006; King et al., 2019; Kvale & Brinkmann, 2009; Yeo et al., 2014). For this study, semistructured interviews were planned with men as the primary study participants in an attempt to dig deep into their experiences of becoming and being fathers, including their experiences with and reflections on practices in the household and maternity clinics during the prenatal and postnatal periods. I used open-ended topic guides and several probes that I adjusted over time during the study according to the situations of individual participants. The open-ended guide was also useful for help in rephrasing questions that were misinterpreted by the participants, and to delete and add questions and probes to make the interview guide as relevant as possible to that which emerged as central themes during the interviewing.

The interview guides focused on the following topics: experiences and practices of fathering and fatherhood; practical household responsibilities of men and women during pregnancy; forms of social support for expectant families; and men's experiences of maternal health

services (see Appendix III and VI). Interviews provided men with an opportunity to describe their personal lives in ways that may not have been possible in a FGD.

Interviews also provided an opportunity to build a relationship between expectant fathers and the researcher. Expectant fathers were not interviewed immediately after recruitment. In both Accra and Afram Plains, I introduced the aims of the study to participants on the day that they were recruited at which point we agreed upon a date and time for the interview. In Accra, I followed-up with phone calls later in the day or the next day to maintain their interest and in some cases followed-up with a second reminder before the interview. These follow-up calls did not only work to maintain their interest in the study, but were also a part of building rapport between the participants and myself before the interview. It seemed like these rounds of communication made most men comfortable enough to readily share their views, sometimes including matters beyond what was included in the topic guide.

My interaction with participants differed from one participant to the next. The Accra fathers were open during the first phase of data collection and became even more relaxed during the second round of interviews, such that our interactions transpired very naturally. The Sakora fathers were initially more reserved, and I had to use more probes. However, I came to learn more about the Sakora male participants through observations and informal conversations. At the outset, men were scheduled to be interviewed alone. Nevertheless, two couples (one in Accra and one in Sakora) were interviewed together. One mother was also interviewed separately in addition to her husband in Accra. Moreover, two mothers-in-law were interviewed to share their views on fatherhood, fathering and masculinities, and women's expectations of men in intimate relationships. Interviews with mothers were conducted using an adapted version of the topic guide used for men. The findings from the interviews with women were quite similar to the data emerging from the FGD with women (see below), leaving little motivation for conducting more such interviews.

Four midwives, one public health nurse, and one health education volunteer were interviewed using a topic guide that focused on health workers' practices, challenges and strategies for involving men in maternal health services and the influence of gender norms on men's engagement in maternity care (see Appendix V). Three community health nurses (CHNs) in Sakora were also engaged in a group interview. Interviews with health workers provided them with a space to be more open about their personal views and working conditions. In addition, the group interview with CHNs in Sakora provided insights on social norms in the community. Interviewing these health workers established a rapport between health workers in the community and myself, which facilitated my stay and fieldwork in the village. Two employees at the Afram Plains North District Commission for Human Rights and Administrative Justice (CHRAJ) office were also interviewed together. This interaction had begun as an informal conversation, but led to a scheduled interview because they proved to have a lot of information about the social context and on issues of relevance for gender norms and fathering practices in Afram Plains.

All interviews were pre-arranged based on the convenience and choice of the participants. In Accra, interviews were conducted at the health facility, the homes of study participants, and meeting places in the city. In Sakora, interviews were conducted either at the homes of the participants or outside under the shade of trees. Interviews were conducted in Twi and English, lasted approximately 45–90 minutes, and were tape-recorded with the permission of the participants.

4.6.2 Focus group discussions

Focus group discussion (FGD) "involves a focus on specific issues, with a predetermined group of people, participating in an interactive discussion" (Hennink, 2014, p. 1). FGD is conceived to consist of a group of people (approximately four to ten) who share similar social backgrounds

such as gender, age, residence, and experiences vital to the topic under study (Krueger & Casey, 2009). FGD is perceived as an efficient method for gathering a range of opinions over a short period from a group through informal interactive exchanges and everyday communication approaches (Hennink, 2014). I planned to facilitate FGDs for women only to gather a variety of opinions on social expectations of men in the household during pregnancy and after childbirth. Unlike men, whose personal experiences were the study's focus, women were expected to engage with each other in a discussion of general norms, expectations and reflections on men's participation in the care for pregnant partners and households, but without delving into their personal lives.

FGDs were facilitated as follows: I introduced the topics, asked introductory questions and follow-up questions, and encouraged participants to interact with each other. FGDs had four to ten participants per session and lasted approximately 45–70 minutes. In total, seven FGDs were conducted: one with community health nurses (CHNs) in Accra, three with women in Accra, two with women in Sakora, and one with men in Sakora. The following paragraphs describe the FGDs that I facilitated for this study.

The first FGD included six CHNs in Accra. Initially, I had planned to engage health workers only through individual interviews. Although CHNs formed the majority of health workers at both the maternity and child welfare clinics, it turned out that they spent a limited amount of time daily at the hospital because they spent much of their time in community outreach. FGD proved to be a convenient way to collect the opinions of CHNs on men's engagement in maternity care in a short amount of time. The FGD literature highlights the importance of creating groups that are relatively similar in background in order to make them feel relaxed (Finch et al., 2014; Green & Thorogood, 2018). Since the nurses had similar working experiences in community outreach and child welfare services, FGD created a natural environment for them to reflect on their work experiences with mothers and fathers. The

interview guide for health workers was adapted to a FGD guide for the CHNs. As hoped, the CHNs encouraged each other to share and interact with minimal involvement of the researcher.

The second and third FGDs were held for mothers with children under one year old. These FGDs were moderated starting with a story about the daily life of a couple in Accra, which participants were asked to reflect upon and discuss (see Appendix IV). Follow-up questions were asked based on their reflections on the story. Additional questions focused on topics similar to those on the semistructured interview guide for expectant fathers. Both FGDs had four participants each and took place in a private room at the clinic after the babies had received health services. These FGDs lasted approximately 45 minutes each and remained at the formative stage (see Finch et al., 2014), which is the stage when participants respond more to the moderator than to each other.

Following the same approach that I used for the mothers with small children, I conducted the fourth FGD with nine expectant mothers at the maternity clinic of the hospital. The session lasted approximately 70 minutes. This FGD emerged as the most interactive and generated the most deliberative and informative reflections among women in the study. It appeared that some of the women had been looking for an opportunity to talk about their expectations and experiences of men's roles in the household and their involvement in maternity care. The group was large and six women seemed to dominate most of the conversation. They reflected on their own experiences, articulated different versions of why men should or should not participate in maternity care services, and held a unanimous view on why men should not do too much housework. All three FGDs with women gathered valuable information incorporated in Article III.

The fifth and sixth FGDs were conducted with women in Sakora. One of the FGD had six participants made up of five expectant mothers and one mother-in-law. The second FGD had

four participants, two mothers with small children and two older women. This group included mothers that had been trained by PLAN Ghana, as part of the SHOW project to give support and health education to other mothers in Sakora and neighbouring villages. They were known in the community as *mother support group*. They were included in the study because they were known as opinion leaders in the community, and I anticipated learning a lot about gender relations from the group. Both FGDs lasted approximately 60 minutes each and I used the same guide and approach as was used in Accra. These two groups were interactive and provided detailed perceptions about fatherhood and men's roles during pregnancy in the village. There were no differences in the depth of reflections generated from these two FGDs.

The seventh and final FGD conducted in this study was conducted with men in Sakora. This FGD was not planned as part of the study's data collection approach, but was organised upon the request of the fathers in the community. After men had learned about FGDs with women in the community, they organised themselves and invited the researcher to moderate a FGD. The interview guide for fathers was adapted for this FGD. Men shared their opinions on fatherhood, masculine norms and men's involvement in maternity care in the village. The data generated from the FGD provided more depth than individual interviews with men in Sakora, and thus added important information to the study.

In the FGD, the Sakora men discussed and reflected on the topics raised, referring to their family situations, including sensitive issues that most fathers in the village had not mentioned in the individual interviews. Group members were encouraged by each other to reflect upon their lived experiences from boyhood to adulthood. Because the men had a large range of ages (27–45 years old), they discussed their intergenerational differences and experiences, and some chronicled how their intimate relationships had transitioned over the years. This FGD elevated the explanatory strength of the overarching theme, 'becoming and being fathers', discussed in Article I. The interaction and personal experiences generated from this FGD confirm one of the

prominent advantages of the method highlighted by qualitative research experts (Finch et al., 2014, p. 213; Green & Thorogood, 2018, p. 155).

4.6.3 Observations

Observation comprises the process of immersion in the lives and activities of research participants for an extended period of time to record "actions, interactions, routines, rituals and dialogues" (Nicholls et al., 2014, p. 244). Observation has been conceded as the substructure of qualitative studies because of its importance in generating data from natural settings (Bratich, 2018; Green & Thorogood, 2018). Through observation, researchers may perceive mundane (seeming) features that participants may obscure or think of as not worthy of reporting in interviews or FGDs (Atkinson & Pugsley, 2005; Creswell, 2014; Green & Thorogood, 2018; Pope & Allen, 2020). Scholars have established four types of observations depending on how much "immersion" researchers do, namely complete observer, observer as a participant, participant as an observer, and a complete participant (Creswell, 2014, p. 191; 2016; Green & Thorogood, 2018, p. 175).

This study began with my observations at the hospital in Accra with the initial role of a 'complete observer', then switching between 'participant as observer' and 'observer as participant' roles over a seven-month period. At the hospital, I primarily observed the daily activities at the maternity and child welfare clinics. At the maternity clinic, I sat close to the entrance of the waiting hall and observed attendants coming to the clinic and noted expectant mothers arriving with their partners. I paid particular attention to the men and recorded the location they sat, their body language, and the level of participation in processes and activities at the clinic. I accompanied male attendees that I had already recruited or interviewed in order to observe their participation in the different events at the clinic.

From the observations, I was able to follow how activities were organised at the clinic. I learned that the maternity clinic began with a Christian worship session, followed by an exercise session for all mothers and a general health educational session led by midwives. I participated in the worship and exercise sessions and then quietly observed the general educational sessions. When the education session ended, I went around the maternity clinic building to look for male attendees who did not sit in the waiting hall and engaged them in informal conversations. I started visiting the child welfare clinic after a period of observation at the maternity clinic. Here, I helped mothers carry their babies and prepare them for immunisation. After a period of observation at the maternity and child welfare clinics, I started recruiting mothers for FGD and fathers for interviews. The description of the maternity clinic and how services are organised presented in Article II were based on my observations.

The Accra hospital also organised pregnancy school for expectant mothers once a month, routinely on the second Saturday of every month from 9 am to 12 noon. I participated in these sessions three times during the first data collection phase and once during the second phase. I learned that these sessions were mainly focused on giving educational health messages to expectant parents and their families. Very few men participated in these sessions, which in all included over 100 women. During my first observation, there was no male partner. In the second, there were three men, which was the highest number I encountered during the fieldwork. The two subsequent sessions included only one male partner each. At the pregnancy school, mothers were grouped according to the stage of the pregnancy for trimester-specific messages. I assisted health workers in organising the sitting spaces and served food and water to expectant mothers and their families. I moreover engaged in informal conversations with mothers and fathers.

Observation in participants' homes in Accra was very limited. I initially planned to carry out all interviews at participants' homes and use that as an opportunity to conduct small sessions

of observations. The first two interviews were scheduled and held in participants' homes. However, these engagements emerged as uncomfortable for both participants and myself, which limited our level of concentration on the interviewing process. Consequently, I stopped going to participants' homes for interviews. However, participants who were interviewed during the second phase of data collection became open and comfortable to my presence in their homes for interviews and informal conversations.

Observation in Sakora took the form of switching between the 'participant as observer' and 'observer as participant' roles for a period of one month. I lived in the community and participated in community gatherings, went to the market to observe activities, and visited participants' homes with a key focus on the tasks that men and women performed in the households. My visits to participants' homes were for interviews and upon their invitation for a meal. I also went to community members homes to thank them for gifts of foodstuff, to visit sick community members that I had built acquaintances with, to buy foodstuff, and on a few occasions, to stay with women when they made gari (cassava flakes) for commercial sale. Additionally, I sat with men in the shade of trees in the evening and joined in their conversations. I spent time in a convenience shop owned by one participant, where I sometimes interacted with people coming in and out. Moreover, I spent time at the Community-based Health Planning Services (CHPS) compound on weekdays to observe how health services were organised.

These interactions provided insights into the practical daily activities of men and women in the village, which are discussed in Articles I and III. Throughout the observation phase, I took field notes and engaged men, women, and health workers in informal conversations. Informal conversations were unstructured and unplanned but generated beneficial information on context, health workers' challenges, and the attitude of men and women at health facilities.

Information from these conversations has been included in the findings upon the consent of the participants.

4.7 Data Analysis

Saldaña notes that to analyse is to "observe and discern patterns within data and to construct meanings that seem to capture their essences and essentials" (2014, p. 584). Similarly, Simons (2014, p. 464) describes analysis as a process circumscribing the ability to reduce large amounts of data into themes that can summarise the central meaning in the research material. Qualitative data analysis has been conceptualised as continuous and iterative processes such that analytic models are mainly expected to guide rather than instruct (Bazeley, 2013; Liz Spencer et al., 2014). The analysis of this study was inspired by Victoria Braun and Virginia Clarke's (Braun & Clarke, 2013) six phases of thematic analysis (TA).

Braun and Clarke's (2013, pp. 201-202) six phases of analysis comprise transcription, reading and familiarizing with the transcripts, coding, searching for categories/themes, revising categories/themes, defining final themes, and writing the results. Braun and Clarke's (2013) model of TA is a malleable method that guides researchers with minimal instructions and procedures (see also Nowell et al., 2017). TA also provides the flexibility of working simultaneously with multiple data sets collected from different methods and diverse participants (Nowell et al., 2017). Since I gathered data using multiple methods, that is, interviews, FGDs, observation and informal talk, and from different categories of participants, TA was perceived to be a convenient and cogent framework for the analysis. Following the TA guidelines, I coded, developed categories, and arrived at themes from the field notes and the transcripts.

4.7.1 Analysing field notes

Analysis began immediately on the first day of observation, when I wrote field notes about how men and women related to each other at the maternity clinic. Field notes were analysed

alongside interviews and FGDs in three ways described by Phillippi & Lauderdale (2018). First, they were used to provide in-depth description of the research setting. The description of the structure of maternity services of Article II was primarily created from observational notes rather than from the interviews and FGDs. Field notes were also added to specific interviews and FGDs to contextualise them. One code, 'escorts' (which makes up the central topic of Article II), was developed from observation and field notes. Furthermore, I recorded my reflections as a researcher and my feelings and thoughts about the study settings and participants as field notes and consolidated them into the topic of reflexivity and the role of the researcher (Chapter 6).

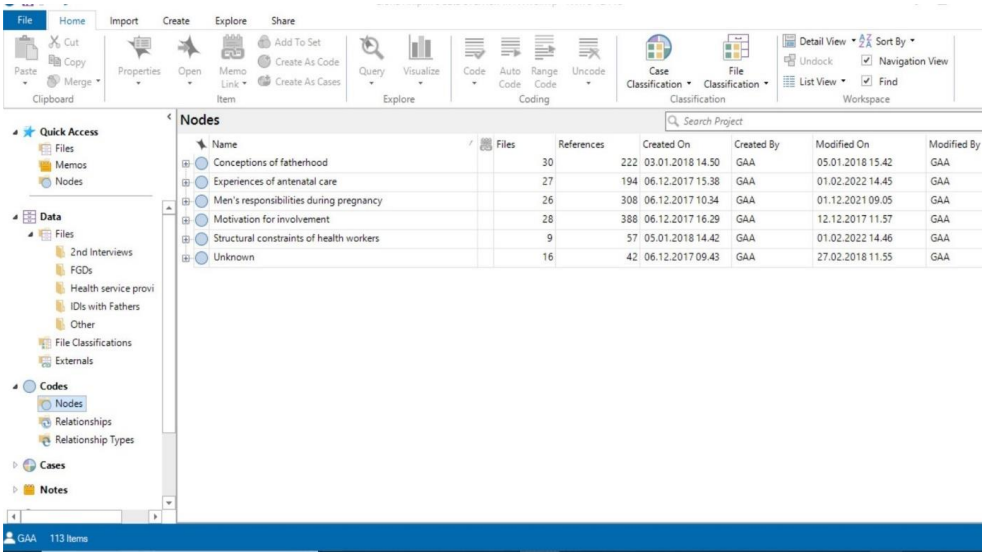
4.7.2 Transcription, coding and categorising data

After the first two interviews, I transcribed and read the transcripts thoroughly to study the pattern of the interview and the core issues that were important to the participants, in order to guide subsequent interviews and gain insight into what could be improved. Upon the completion of interviews and FGDs in the first phase of fieldwork, all tape-recorded audio files were transcribed verbatim with the help of a research assistant. The autumn of 2017 was dedicated to auditing and reviewing transcripts to ensure that the use of terms and meaning from the original language were correct and consistent. This process was effective since I had conducted all interviews and FGDs myself. After auditing and reviewing the transcripts, the next phase involved reading and re-familiarising myself with the data. Nowell and colleagues (2017, p. 4) suggested that preliminary findings and interpretative thoughts should be presented to colleagues in order for the researcher to get 'objective' feedback that could assist coding strategies. For this study, I presented the findings and my initial ideas about themes to colleagues at the University of Bergen on several occasions, and this process of debriefing became significant in later coding decisions.

I printed a few transcripts and coded on paper to formulate a preliminary coding manual. In line with Saldaña's (2016, p. 19) coding recommendations, the material was coded based on significant excerpts of the meaning unit rather than coding every sentence. Some of the initial codes include love and understanding, the condition of the woman, fatherhood is a role, fatherhood is biological, escorts, women-centred, women's space, isolation, lazy women, responsible men, men's personality, shyness, paternal anxiety, sharing chores, chores are voluntary, among others. After preparing a preliminary coding manual, all transcripts were transferred to QSR NVivo Software, where the remaining data were coded.

The next phase involved coalescing codes to form categories, which began after coding the fourth transcript and continued until all transcripts were coded. From this point, there was a constant moving back and forth to cluster codes into groups to form categories. These categories contained "central organising concepts" (Braun & Clarke, 2013, p. 224) or "consolidated meaning" (Saldaña, 2016, p. 10), representing various ideas in the data. Some codes did not fit into any of the categories and so were left as unknown in the beginning. While some of these codes became part of categories at a later stage, others remained unused. Because some codes cut across the concepts, I wrote memos to link them within the NVivo software. Co-authors of the peer-reviewed articles, especially my main supervisor, contributed to this analysis of the data material. My main supervisor read parts of the transcripts, approved initial codes, and participated in the formulation of sub-categories, categories, and themes that were described in the peer-reviewed articles. Below is a display of the overview of codes and categories of the data material as they appear in the NVivo software.

Figure 2. Display of categories in NVivo



The five categories that I used in writing the three peer-reviewed articles were: conceptions of fatherhood; experiences of antenatal care; men's responsibilities during pregnancy; motivation for involvement; and structural constraints of health workers. Working in NVivo was a cumbersome process in the beginning when a lot of time was spent reading and re-reading and coding transcripts. However, once all transcripts had been coded, NVivo proved to be a useful platform for collating, retrieving, and visualising the data. It also provided the convenience of accessing all codes related to a concept using a click or simple search terms.

4.7.3 Reaching final themes

Spencer and colleagues (2014, p. 311) have recommended that researchers should work outside software when moving into deeper conceptualisation and analysis. Following this recommendation, analysis beyond NVivo involved printing out the material forming the categories illustrated above and reading them multiple times. While preparing the three articles

that are part of this thesis, I shared tentative themes with my supervisor and co-authors to identify and agree on dominant patterns in the data.

Braun and Clarke (2013) suggest that the final themes should provide a rich, coherent, and meaningful picture of the core ideas in the data and address the study's objectives. They also argue that good themes should make sense on their own and simultaneously interlink with other themes to encapsulate the overall analysis (Braun & Clarke, 2013, p. 231). The co-authors of the peer-reviewed articles and I developed the three final themes across the categories shown in Figure 2 above through a process of continuous review and revision during the writing of the articles. Theme 1 discussed in Article I is 'becoming and being a father', which was developed from the two categories 'conceptions of fatherhood' and 'men's responsibilities during pregnancy'. Theme 2 discussed in Article II is 'men's experience of maternal health services' and was created from the three categories: 'experiences of ANC', 'motivation for involvement' and 'structural constraints of health workers'. Theme 3 discussed in Article III is 'shifting household gender relations', and was formulated from 'men's responsibilities during pregnancy' and 'motivation for involvement'.

The overarching strategy of this study was to focus on the experiences and accounts of men as the primary participants. In so doing, not all data collected and analysed have been included in this dissertation. Data generated from interactions with women were analytically valuable in understanding men's narrated experiences of fathering practices in the household and their involvement in maternity care services in Article I and Article II. Nonetheless, they were only included as part of the data material in Article III. Interviews with health workers in the rural area have only been utilised to the extent that they have provided contextual understanding for the study. Moreover, I gathered data on the role of the extended family during pregnancy and after childbirth, which has not been included in this dissertation.

4.8 Ethical considerations

The study followed the protocols of the Norwegian Institute for Data Protection and the University of Ghana, College of Health Sciences granted ethical approval, and approvals from both institutions are Appendix I. These ethical review procedures provided a platform for discussing the study's intentions and reflecting on the proposed research processes to ensure that the study would not cause any harm to participants and that participants would trust the process enough to participate. Ethical review was essential for strengthening the integrity of the study and satisfying the academic and publication requirements (Guillemin & Gillam, 2004). In addition to the formal ethical reviews, the study adhered to universal ethical codes of informed consent, confidentiality, and anonymity.

4.8.1 Informed consent

Informed consent underscores that all relevant information about the study aims and processes are disclosed to participants; that they can comprehend and are capable of making a rational judgement of the processes explained; and that their agreement to participate is voluntary and devoid of coercion (Green & Thorogood, 2018, p. 89; Kvale & Brinkmann, 2009). Researchers have pointed out that, perhaps especially in health facility settings, gatekeepers (health workers, administrators, etc.) can obstruct the process of informed consent because participants may feel obliged to participate upon gatekeepers' requests (Franklin et al., 2012). In many cases, therefore, informed consent is articulated as a continuous process that should be carefully integrated in the research process (Goodwin et al., 2020).

The gatekeepers themselves were very useful in this study in both Accra and Sakora in gaining access to the field. In Accra, gatekeepers were neither influential in selecting participants nor were they an impediment to obtaining informed consent. Before the research began in Accra, I thoroughly explained and gave a copy of the research protocol to the administration of the

hospital and the managers of the various units. In addition, I distributed information letters about the study to all health workers in the maternity and child welfare clinics. Moreover, over the seven-month period, health workers were continuously informed about the study and their rights to withdraw from participation at any time. Some health workers decided not to participate in interviews and FGDs, but did not withhold their consent about observation. I continued to engage the administration and managers of the selected health facilities, including reporting on the study's progress to maintain their interest and secure consent.

The study was explained at the clinic to women and men who were observed on some occasions. Hence, not all people observed gave their consent because they were unaware of the study. However, consent was obtained from men (and their partners) and women who were engaged in informal conversations. In Sakora, the study was introduced through a general announcement to the community. Additionally, I integrated informed consent as a continuous process throughout my stay in the village in a manner so that residents who were observed and interviewed were constantly reminded of the purpose of the study and voluntary participation.

Prior to the scheduling of semistructured interviews and FGDs in both Accra and Sakora, I obtained written/oral informed consent from all participants, and again on the day of the scheduled interview or FGD, all participants were reminded of the purpose of the study and voluntary participation. In addition, consent was sought from the female partners of all male participants in both Accra and Sakora. The information letters presented to study participants and female partners of male participants are in Appendix II. I gave information letters to participants to read and receive their written consent or I orally translated for participants who could not read in order to receive their oral consent. I emphasised their right to stop at any point without facing any consequences, and two participants in one FGD left before the meeting ended. Interviews and FGDs were tape-recorded only with the permission of participants.

4.8.2 Confidentiality

Confidentiality involves keeping data and information gathered for research purposes private and not disclosing information to people outside the research team in ways that will identify the study participants (Goodwin et al., 2020; Webster et al., 2014). Confidentiality can be a slippery slope for researchers because it can be breached unknowingly. For example, data may be presented or shared in ways that identify participants. An even more complex scenario can be encountered in group interviews and FGDs if members of the group share information with people who did not participate in the study (Webster et al., 2014).

To ensure confidentiality, I reached an agreement with participants before each interview and FGD to keep information shared at the sessions private, and that it should not be divulged to people outside the group. During FGDs, group members were encouraged not to mention names of other participants or mention names of people when giving examples. On the part of the research team, none of the information gathered was shared with other participants, gatekeepers, or experts in the field without anonymising the data.

4.8.3 Anonymity

Anonymity involves obscuring the research location and changing the name of participants so that it and they cannot be identified easily (Goodwin et al., 2020, p. 34). To enhance anonymity, all participants in this study were given pseudonyms. Moreover, the hospital and community where the study was undertaken were pseudonymised to enable the descriptions of study contexts without giving clues that identify study participants.

4.8.4 Research dissemination

Dissemination is understood as engaging stakeholders and communicating findings through channels that are open and accessible throughout the research process to a broad audience, including the study participants (Green & Thorogood, 2018, p. 362). To circulate the findings

of the study to the participants and audiences beyond academia, two popular science articles were published in *The Conversation*, Africa. These articles were circulated on social media and shared with the Afram Plains North District Health Directorate and the Hospital in Accra where data were gathered. One of the popular science articles was also published in a local print media in Ghana. Furthermore, I have shared published articles with the Afram Plains North District Health Directorate and the administration of the hospital in Accra.

5 Synopsis of the articles

5.1 Article I

Making Fathers: Masculinities and Social Change in the Ghanaian Context

This first article included in the thesis explores men's journeys from boyhood to manhood and fatherhood and investigates norms, practices, and experiences that define who can be referred to as a father and an adult man. The findings presented in the article were collected from semistructured interviews, observations, and a focus group discussion conducted with men in urban and rural Ghana. Concepts of adult masculinity and emergent masculinities were adopted to interpret men's narratives, practices, and experiences.

From the men's accounts, transitioning from boyhood to manhood manifested in maintaining intimate relationships, being able to provide for nuclear family and kin, and having biological children. However, among both urban and rural participants, it emerged that men were also increasingly expected to respect and show affection for their partners and children, and show support by performing household chores. Conjugal faithfulness and avoiding polygamy, moreover, appeared as novel values related to fatherhood, especially among the urban participants.

The article underscores that hegemonic masculinity appeared from participants' accounts as adult masculinity, that is, the ability to provide for the nuclear family and have biological children. The discussion of the paper further suggests that alongside adult masculinity, norms of involved fatherhood and elements of emergent masculinities manifested among young Ghanaian fathers studied. These tendencies were exemplified in the men's expressions of conjugal fidelity, the importance they gave to showing love and affection for partners, spending time with the nuclear family, and their willingness to do a certain amount of housework.

5.2 Article II

"I came to escort someone": Men's experiences of antenatal care services in urban Ghana – a qualitative study

Based on semistructured interviews with fathers and midwives, a focus group discussion with community health nurses, and observations, this second article sheds light on the experiences of men attending antenatal care services (ANC) services with their partners in Accra. The theme of the paper centres on the nexus of expectant fathers' experiences at ANC and health workers' perceptions and initiatives in involving men in maternity care services. The research findings are analysed within the conceptual framework of gender, space, and place.

The findings show that ANC normally began with a general educational session in a waiting area, followed by individual consultation with assigned midwives. Few men sat with their partners in the waiting area during the educational session — most stayed outside under trees and in empty spaces. While some men joined their partners for the individual consultation, others spent their entire time at the ANC waiting outside. Men attributed their reluctance to stay in the waiting area to shyness and discomfort in a space that was largely occupied by women. Expectant fathers performed varying roles at the clinic such as making payments, donating blood, and carrying partners' handbags and folders during the clinic's proceedings. Men talked about their motivations for attending ANC, which were to learn and remind their partners of essential health messages and to show love and respect to their partners. Many male partners expressed disappointment that there were no direct health messages for them and no initiatives to engage them while they were at the clinic.

Health workers acknowledged that there was inadequate physical space in the waiting area for male attendees and insufficient personnel to engage men in separate spaces. Health workers gave preferential treatment to women accompanied by men to incentivise male participation.

Feminist geographers' analyses of space, place, and gender was a productive lens for discussing expectant fathers' discomfort with sharing the space at the maternity clinic with expectant mothers. The article articulates that the maternity clinic has emerged as a 'third place' for expectant mothers and simultaneously that it has been constructed as a 'feminine space' over time. The paper suggests that male partners stayed outside because they felt spatially and socially out of place. The article illustrates that while advocating for male involvement in maternal healthcare, it is vital to review the socio-spatial construction of maternity clinics. At the same time, maternal health services should not lose their core aim of providing care to expectant mothers in an eagerness to garner male participation.

5.3 Article III

"I do not want her to be doing anything stressful": Male involvement in domestic work during pregnancy in Ghana

This third article investigates the interface between potential changes in gender practice among couples and the pursuit of harmony between intimate partners during the time of pregnancy in urban and rural Ghanaian households. The data draws on both men and women's accounts of practical tasks that men perform in the home during the period of pregnancy and their perceptions of possible permanent changes in household gender practice. The discussions in the article drew on the theory of '(un)doing gender'.

The data indicate a relaxation of gendered division of household labour during the time of pregnancy. Men reportedly performed a number of household tasks that have been culturally labelled as feminine, in addition to their normative task of providing the family's income. They washed clothes with their hands, cooked, and cleaned the house. In the rural community where farming was the main occupation, male partners sometimes took up a large portion of the farm work, including the parts normally carried out by women, so that their female partners could

rest at home. In the urban setting, expectant fathers carried out a large portion of the housework including tasks that they said they do not like to perform, like handwashing of clothes. In both settings, men could be ridiculed for doing women's work in the domestic arena, yet many male study participants mentioned that their contributions to the nuclear family were more important to them than what members of the extended family or community thought.

Despite the flexibility of the performance of household tasks among couples during pregnancy, it appeared in both rural and urban narratives that 'excessive' male involvement in housework could inspire laziness among women. Female participants argued that women should not leave most of the housework to their partners during pregnancy to avoid conflicts in the household. Male participants also contended that women sometimes overstretched men's willingness to perform housework at the time of pregnancy, and instead of sharing the chores, they expected men to do most of it. Participants argued that men carrying out housework should be a form of support provided to women during pregnancy when they were tired or experiencing complications, but should not become men's normal chores, neither practically nor normatively.

Drawing on the 'doing gender' framework, the article suggests that women were expected to accomplish gender by performing housework while men were expected to accomplish gender by providing their family's income. The period of pregnancy, however, exemplify a time when gender practices were not enacted according to the normative cultural repertoire. Acts of 'undoing gender' were evident in men's increased performance of housework during their partner's pregnancy. However, it appeared that men and women resisted a permanent 'undoing gender' when they argued that men's performance of housework should be a form of support rather than become the standard practical and normative pattern. The article concludes that acts of 'undoing gender' emerged as temporary attainments to specific life changes rather than permanent transformations in gender relations.

6 Discussion

This chapter is organised in two parts. The first part discusses the core findings of the research that formed the bases of the three peer-reviewed articles briefly summarised in the previous chapter. Here, I attempt to provide a discussion of three overarching themes that emerged in the data, which are centred on men's expanding roles during their partner's pregnancy, the construction of masculinity, and the negotiation of gender orders. The section ends by revisiting the main objective of this research, which is to shed light on how men's care for their households and partners during the time of pregnancy, and the emerging norms of fatherhood and masculinity in this study, can modify unequal gender relations. In the second part of the chapter, I reflect on the strengths and weaknesses of the methodological approaches adopted in the conduct of this study.

6.1 Discussion of study findings

6.1.1 Men's care for their partners and households during the time of pregnancy

The findings of the present study feature both men's involvement in health seeking and contextual explorations of what men do in the home setting during their partner's pregnancy. All three articles have subtly delineated multiple roles that men played to promote positive health outcomes for their partners and children during the time of pregnancy (Agyare et al., 2018; Alemann et al., 2020; Ampt et al., 2015; Plantin et al., 2011). In Sakora, men provided financial resources, increased their performance of housework, took up most of their partner's farm work during pregnancy, and assisted with adherence to nutritional supplements and prescribed medications. Men's attendance at ANC was almost non-existent in the rural area. Articles I and III showed that the provision of financial resources appeared more valuable to both men and women in the rural area than attending ANC services. Men who attended ANC

services in the urban area had different reasons for participating, including giving their partners financial, emotional, and social support.

The study suggests that men's participation in the care for their pregnant partners appears to be varied and reverberates with what men and women find important. Bougangue and Ling's (2017) study in another Ghanaian setting corroborates that men participate in maternal healthcare according to their culturally-defined roles of providing material resources. In terms of clinical care, Bougangue and Ling's study revealed that men preferred to arrange for other women in the family to accompany their partners for maternity care services. These findings resemble the findings from other Sub-Saharan African contexts like Tanzania, Malawi, South Africa, Sierra Leone, and Rwanda (Gibore & Bali, 2020; Manda-Taylor et al., 2017; Matseke, Ruiter, Barylski, et al., 2017; McLean, 2020; Påfs et al., 2016). Together, these studies substantiate that men's levels of involvement in the care for their partner's pregnancy are diverse and this involvement may or may not include attendance at maternity care services (Galle et al., 2021; McLean, 2020; Powis, 2020).

McLean (2020) emphasised that already prior to the shift to male involvement in global health discourse and government agendas on sexual and reproductive health, African men had performed (and continue to perform) a plethora of roles during pregnancy and childbirth. Similarly to what the present study has demonstrated, these roles are expanding (for some) to include participation in clinical care, while others carry out several activities in the household to support expectant partners. In both the urban and rural settings, men's roles are expanding to include norms of involved fatherhood (Farstad & Stefansen, 2015), such as playing with children and spending time with the nuclear family. These accounts of men's roles in the family setting, and the emphasis on emotional involvement with their partners and children, underscore small but important adjustments in men's parenting practices irrespective of their attendance at

maternity care services (Comrie-Thomson et al., 2019; Inhorn, 2012; McLean, 2020; Smith, 2015).

6.1.2 Continuities in and expansion of masculinities

The study indicates that hegemonic masculinity (Connell, 2005) is manifest in the data and resonates with what I refer to as adult masculinity. Miescher (2003, 2005, 2007) originally discussed adult masculinity as achieved through marriage, biological fatherhood, and providing for the nuclear family and kin. In the present study, the most preferred way of being a man can be crystallised into maintaining a stable intimate relationship, having biological children and providing for partner and children, which reverberates with Miescher's (2007) conceptualisation. Because adult masculinity appeared to be the currently most favoured way of being a man, it can arguably qualify as hegemonic masculinity (Bloksgaard et al., 2015; Christensen & Jensen, 2014; Connell & Messerschmidt, 2005). Other Ghanaian studies have likewise indicated what I describe as adult masculinity as expected of young men (Adomako Ampofo & Boateng, 2007; Adomako Ampofo et al., 2009; Dauncey, 2016; Dery, 2019, 2021; Dery & Akurugu, 2021; Esson et al., 2021).

Hegemonic masculinity influenced men's participation in maternity care services as described in Article II. In the rural area where more emphasis was placed on men's breadwinning roles, men's attendance at maternity care was nearly non-existent, although they provided money for the service. Men's agendas at the urban clinic included making payments for care, learning and reminding partners about important health messages, and asking questions that they felt their partners would be unable to ask. These agendas appeared as expressions of men's normative roles as breadwinners, and as intelligent and supportive heads of their household, signifying the constant desire to embody hegemonic masculinity (see also Newton et al., 2018). The maternity clinic presented a gendered space where men were marginalised, and they seemed to have lost

at least parts of their confidence and autonomy. Article II discussed the idea that, to reaffirm their masculinity, some men desired separate sessions for male attendees, while others were keen to participate in private consultations, which only included their partners (i.e. the pregnant women) and health workers, in order that they could be heard and seen in a more distinct manner.

Alongside the persistence of adult masculinity, the pursuance of more gender-equal household arrangements emerged from participants' discussions. Article I illustrated men's desires for increased equality, love, and mutual respect in conjugal relations. Rural men talked about playing with and cooking for their children. Urban men talked about spending time with their partners and children in addition to doing away with polygamy and infidelity in intimate relationships. In Article II, expectant fathers mentioned spousal love, affection, and respect as motivations for joining their partners at ANC services. Article III moreover highlighted the increasing involvement of men in housework. These additional roles and desires of men illustrated in the articles exemplify what has been referred to as gender-equality oriented masculinity or non-dominant masculinity, and these contain elements of involved fatherhood, which is being emotionally and physically involved with children (Bach, 2017; Bloksgaard et al., 2015; Farstad & Stefansen, 2015). The findings here are in line with evidence from other studies that have underscored trends of non-dominant masculinity in Sub-Saharan African contexts (Dery & Akurugu, 2021; Groes-Green, 2012; McLean, 2021; Smith, 2015).

It is noteworthy that men's embodiment of non-dominant masculinity in the home, especially during pregnancy and childbirth, was related to love, equality, respect, and choice. Wallace and Adongo's (2018) study in a rural Ghanaian setting similarly found increased spousal communication, love, and an erosion of polygamy among young couples. The findings of the present study and Wallace and Adongo substantiate arguments among African scholars that love is complexly allied to gender practice in intimate relationships and should be more strongly

integrated into the analysis of gender equality in household arrangements (Bhana, 2013, p. 6; Comrie-Thomson et al., 2019, p. 734; Mudaly, 2013; Vincent & Chiwandire, 2013).

I argue that the evolving masculine practices in this material, that is, the mixture of adult masculinity, gender-equality oriented masculinity, and norms of involved fatherhood, can all be understood within the framework of emergent masculinities (Inhorn & Wentzell, 2011). Inhorn and Wentzell (2014, p. 694) have described emergent masculinities as men's interest in contributing to their family, pursuing romantic love and collaboration, and performing "companionate responsibility", that is, combining breadwinning with fidelity, intimacy, and care. Emergent masculinities is a useful concept for discussing men's everyday practices and navigation of social norms in a manner that neither conflicts with nor erases hegemonic masculine forms.

Consistent with the conceptualisation of emergent masculinities, the discussions of the research findings in all three articles illuminate a complex co-existence of hegemonic masculinity and novel symbols of manhood that do not trade on female subordination. The pursuit of companionate relationships, respect, love and harmony between intimate partners represented in the findings does indicate the embodiment of new practices. The additional responsibilities that men take on and accept, including tasks that have been culturally described as feminine, do not obliterate or conflict with adult masculinity. Rather, it appeared that men make decisions on how to manoeuvre their daily lives in collaboration with their partners while holding on to established hegemonic masculine norms, suggesting the persistence of coinciding gender practices, that is, adult masculinity and emergent masculinities. This co-existence of adult and emergent masculinities corresponds with scholarly arguments that multiple masculinities can thrive simultaneously in Sub-Saharan African contexts (Cornwall, 2003; Dery & Akurugu, 2021; Groes-Green, 2012; Lindsay & Miescher, 2003; Miescher, 2003).

Nonetheless, men still drew on hegemonic masculinity to defend expanding acts of manhood. Articles I and III indicate the possible stigmatisation of men who carry out culturally-marked feminine tasks in the household. To justify their practices in the household, men framed their decisions within a narrative of choice (Bach, 2017), and presented themselves as independent thinkers and decision-makers with autonomy in their households. As scholars have comprehensively discussed, such accounts of choice do not symbolise political actions against conventional gender scripts, rather, they trade on hegemonic norms of courage, strength and the determination of men to 'do femininity' (Bach, 2017, p. 352; Wetherell & Edley, 1999, p. 350).

6.1.3 (Re)Negotiating gender orders – Seeking harmony and protecting gender practices

In this sub-section, I discuss participants', and especially women's, resistance to permanent changes in men's performance of household chores, and, in the same vein, a defence of feminine space.

Seeking harmony in household relations

The research findings show that women's work outside the home was obscured and unaccounted for in the discussions of gender practices in the household. Even though most of the female participants in the study were engaged in waged labour, and thus surely contributed to the household resources, the emphasis when narrating shifts in the division of labour was mostly based on men doing housework. Other studies have similarly argued that although Ghanaian women have always been engaged in waged labour outside the home, members of the household are likely to idealise divisions of household labour along male breadwinner/ female domestic-caregiver model (Adomako Ampofo & Boateng, 2007; Atobrah & Adomako Ampofo, 2016; Boni, 2002; Clark, 1999). In Article III, it was underscored that the unintentional 'hiding' of women's contributions to the family income is linked to gender

accountability and the expectation that men and women should 'accomplish gender' (Hollander, 2018; West & Zimmerman, 1987). Providing the family's income is regarded as an appropriate norm for the sex category 'male', implicitly meaning that women do not accomplish gender by performing this task. Conversely, doing housework is an assumed norm for the sex category 'female', and therefore men do not accomplish gender when they carry out housework.

As we have seen, men increased their performance of housework during pregnancy and some men were or imagined themselves as being physically and emotionally involved in the care for their children, as indicated in all three articles. Participants mentioned that men doing the bulk of the housework could encourage laziness and negligence among women. The findings also showed that women could be accused of bewitching their partners to perform housework and men could be ridiculed when they carried out domestic chores. Through these perceptions that police gendered practices, women's accountability as "essentially feminine beings" and men's accountability as "essentially masculine beings" are ensured (West & Zimmerman, 1987, p. 140).

Article III illustrated similar findings from Ghana and Tanzania. The findings from the Ghana study showed that women preferred that men maintained their breadwinning roles and women performed housework (Tolhurst et al., 2008). In Tanzania, Silberschmidt (2001) described a tendency for men to resort to aggressive behaviours when they were unable to provide the family's income. In line with these two examples, Article III suggested that men and women might resist radical transformations in normative gender repertoire, and instead, show an inclination to maintain established social order. Drawing on historical and contemporary studies in Nigeria and Ghana, I suggest additional interpretations that could further enhance the understanding of the determination of both men and women to maintain normative gender relations.

In a study based in colonial south-western Nigeria, Lindsay (2007) showed that although women were engaged in waged labour, they drew on the narrative of the male-breadwinner to gain access to material and financial resources from men while sheltering their own income. Lindsay (2007, pp. 249-250) argued that gender orders do not only shape people, but people also appropriate gender norms for their own good. In this line of thought, it may be posited that women asserted that men should not perform too much housework, in order that they can hold men accountable to the family income. Research indicates that having access to male partner income and material resources reflect being in a relationship with a 'real man' in some Ghanaian contexts (Dery, 2019, p. 182). Like the south-western Nigerian women described by Lindsay (2007), almost all women who participated in this study were engaged in farming, petty trading, and other forms of economic activity outside the home. Yet all of them were keen to idealise hegemonic masculinity expressed as breadwinning and to emphasise femininity described as domestic caregiving. In so doing, women could hold men accountable for providing material and financial resources.

The eagerness of both women and men to maintain established social arrangements has also been discussed in another Ghanaian study (Bougangue & Ling, 2017). Similar to the findings highlighted in Article III, men in that study complained that female partners expected short-term performance of housework to become permanent, and men's refusal to carry out domestic chores created conflicts in the home. Thus, to avoid such misunderstandings, men argued that it was better that they did not participate in housework at all (Bougangue & Ling, 2017, p. 5; see also Pierotti et al., 2018). In contexts where men's involvement in housework could destabilise peace and harmony in the home, men and especially, women may argue that male performance of housework should not become a permanent alteration in gender practice, in order to avoid potential disagreements. As shown in another Ghanaian study, women are considered to be the ones in a family that have "a moral and cultural obligation to maintain a

stable and comfortable home" (Dery & Bawa, 2019, p. 991). Women in the present study could be described as bargaining with conventional gender orders to access men's financial provision or/and to avoid conflicts in intimate relationships (Kandiyoti, 1988). Simultaneously, these discussions demonstrate the obstinacy of normative gendered expectations. Indeed, scholars have argued that even in the most ideologically gender-equal societies, established gender norms could be tenacious (Halvorsen & Ljunggren, 2020; Sevón, 2011).

Protecting feminine spaces

The arena of pregnancy and childbirth generally has been found to create a space of authority for women and senior women in particular, such that women may be reluctant to make room for men (Dumbaugh et al., 2014; Ganle et al., 2016; Påfs et al., 2016). During pregnancy and childbirth, women leverage their knowledge and responsibilities for power and control over key decisions in the household (Dumbaugh et al., 2014, p. 7). Women's appropriation of power in the arena of pregnancy and childbirth can be described as an example of maternal gatekeeping, which may not only limit men's involvement during pregnancy, but also limit the possibility of men to enact norms of involved fatherhood (Makusha & Richter, 2016; Olsavsky et al., 2020).

Article II discussed the maternity clinic as a feminine space. The paper showed that the maternity clinic has become signified as a women's space over time due to expectant mothers and health workers' (who are mostly women) repeated engagement of the space to address women's reproductive health matters. The maternity clinic as a physical place and gendered space may appear as an ordinary feminine space, yet it is one invested with possibilities of women dis/empowerment. The WHO (2015, p. 20) has recommended that male involvement strategies should be formulated in ways that will promote gender equality and augment women's autonomy and decision-making power over their own health. The quest for increased gender equality by including men must not result in women losing autonomy. The recent findings of Galle and colleagues (2019) can serve as a good example of what the WHO was

trying to avoid. In this study based in Mozambique, the authors observed that when men participated in ANC consultations, discussions about women's health flowed between the men and the health workers, leaving the women unable to speak about their own health (Galle et al., 2019, p. 11).

What is more, strategies that involve men in maternity care services by giving incentives such as faster service to women who attend the clinic with male partners are discriminatory and may potentially marginalise unaccompanied expectant mothers (Agyare et al., 2018; Galle et al., 2019; Kululanga et al., 2011; Peneza & Maluka, 2018). Such strategies are incompatible with WHO's recommendation (WHO, 2015, p. 20) that male involvement approaches should be based on women's autonomy and approval of what they find useful and what aspects of health seeking they want their partners to participate in.

Article II also showed that the maternity clinic has evolved as an essential third place (Jeffres et al., 2009; Oldenburg & Brissett, 1982), that is, a place outside the home and workplace, which facilitates social support and connection for women during the period of pregnancy. As a third place, the maternity clinic is imbued with social resources from which individual women can draw for future decisions (Finlay et al., 2019; Holt et al., 2013). Article II further explained that women in the maternity clinic connect and share knowledge with each other about their reproductive health and build vital social support networks for pregnancy and childcare. A Ghanaian study by Ganle and colleagues has similarly shed light on the maternity clinic as a space where women learn from each other and make important decisions about their health, like using contraceptives, without interference from male partners (Ganle et al., 2016, pp. 200-201). Women's access to such spaces, both physically and psychologically, fortifies the acquisition of emotional and social capital relevant for their empowerment, as has been indicated in several writings (Holt et al., 2013; Padmaja, 2016).

Massey (1994) and McDowell (1997b) have both shown that gendered spaces can be 'undone' over time through the interactions unfolding at the place and influences of intertwined places. Accordingly, increased male involvement in the arena of pregnancy and childbirth, combined with increased participation of men in ANC services, can redefine and change the maternity clinic's identity. Concomitantly, re-signifying the maternity clinic may undermine its value as a third place for expectant mothers, and thus dissolve an important space of autonomy for women. Hence, men's inclusion in ANC services presents a puzzle. On one hand, men's increased access to the maternity clinic could potentially disempower expectant mothers and compromise women's autonomy over their health. On the other hand, limiting men's access to the clinic, or a lack of effective engagement of men who attempt to participate in ANC, could marginalise men who are interested in becoming actively involved.

6.1.4 Dismantling the gender system through social practices during the period of pregnancy

So far, this chapter has discussed three core themes that have emerged in this study encompassing men's care for partners and households during pregnancy, the continuities and expansion of masculine and fatherhood norms and practices, and the negotiation and protection of normative gender orders. In this section, I return to the main study objective and discuss how the complex interplay between men's roles during the time of pregnancy, elements of involved fatherhood, and emergent masculinities could initiate permanent changes in gender relations in urban and rural Ghanaian contexts.

The study's findings illustrate a normative gender order that describes manhood as accomplished through stable intimate relationships, having biological children, and providing for nuclear families. Housework and caregiving were mainly expected to be women's work. Following, West and Zimmerman, I understand this normative gender order as scripts for 'doing gender'. Scholars have argued that through repeated interaction in activities like housework, in

which both men and women interact as equally competent participants, gender can be 'undone' (Deutsch, 2007; Ridgeway & Correll, 2000; Risman, 2018). To find acts of 'undoing gender', Deutsch (2007, p. 106) has encouraged researchers to explore "when and how social interactions become less gendered". The findings in this study show that the period of pregnancy marked a time when interactions among men and women in the domestic sphere were less gendered. Men were engaged in activities that were perceived as inappropriate to their sex category, such as performing housework and attending ANC services, and these emerged as examples of 'undoing gender'. Furthermore, the men in this study practised or imagined themselves practising elements of involved fatherhood.

Risman (2009, p. 82) has made the germane argument that researchers should acknowledge acts of 'undoing gender' rather than saying they have found alternative masculinity or alternative femininity. She argued that categorising anything boys/men do as a form of masculinity, and anything girls/women do as a form of femininity, reinforces gender differences, leaving fewer possibilities of displaying similarities between men and women (Adams, 2018; McDonald, 2013; Risman, 2009, p. 82; 2018). I highlight how both 'undoing gender' and hegemonic masculinity emerge in the present study and seek to add empirical and analytical substance to Risman's (2009) argument.

In the present study, we see resistance to substantial adjustments in gender practices in a manner that affirms the identity of the home place and responsibility for housework as feminine. Moreover, men performed household chores albeit framed within a hegemonic masculine discourse of overseeing their households and having autonomy over their decisions. Men and women in a similar manner conceptualised male involvement in household chores as 'assistance' or 'support' rather than housework as a shared responsibility. In this way, it could be suggested that men are 'undoing gender' and simultaneously enacting hegemonic masculinity.

Similar to the findings in the present study, Pierotti and colleagues (2018, pp. 555-556) have illustrated that men in a context in Congo were willing to take up more housework, but on their own terms, and were not willing to discuss with their partners what and how much housework they would perform. Ilomo and colleagues (2021) have likewise demonstrated that men were willing to adjust practices in the public space and even work under women's leadership but reluctant to perform housework, because the latter is perceived as feminine. As shown in the two examples above and similarly articulated in the present study, domestic work remains a foundation for gender accomplishment (Davis & Greenstein, 2013; Pierotti et al., 2018; Sullivan, 2018; Treas & Lui, 2013), even during peak reproductive periods in the lives of intimate partners.

Destabilizing gender orders has been analysed as both rooted in practices in the domestic arenas and policies at the structural levels (Adams, 2018; Deutsch, 2007; Mandel & Lazarus, 2021). For example, paid paternity leave in the Nordic region has been largely associated with the overlapping construction of involved fatherhood norms and gender-equality oriented masculinity (Bach, 2017; Farstad & Stefansen, 2015; Miguel et al., 2019). In Ghana, access to paternity leave is still largely sparse and limited, mostly available for a few days to men who work for private corporations and small portions of the public sector (Anku-Tsede et al., 2018, pp. 116-117). In the absence of family friendly policies, men's desires to practise involved fatherhood norms could be hampered. Subsequently, changes in household gender relations during pregnancy and after childbirth may remain mainly at the private level and dependent on how intimate partners plan and navigate the care for their households during peak reproductive periods.

In this thesis, I have suggested that male involvement in the care for their pregnant partners, the expanding notions of masculinity, and developing norms of involved fatherhood may not be enough to weaken gender inequity and inequality in the domestic sphere. Housework and

caregiving are still largely perceived as feminine work and there are limited institutional frameworks for bolstering small acts of modification in gender practices at the private level. Nonetheless, increased male participation in housework during their partner's pregnancy addresses women's practical needs in the domestic arena. Men doing more household chores implies that their partners may spend less time doing domestic work than usual, thereby reducing women's burden of combining waged and domestic labour (Hanna et al., 2018; Harryson et al., 2016; Sossou, 2003; Waterhouse et al., 2017).

Moreover, as indicated in Article III, men may become more skilful and competent through doing housework during their partner's pregnancy, and subsequently perform domestic chores more easily. As Smith (2015) found in Nigeria, men who perform housework are also likely to share parenting more equally with their partners. Indeed, the results of this study show examples of involved fatherhood norms among young Ghanaian fathers studied. Furthermore, studies have argued that men who experienced their fathers sharing housework are more likely to replicate that behaviour when they grow up (Barker, 2014; Morrell et al., 2016; Morrell & Jewkes, 2011). Similarly, girls who see their fathers doing domestic chores have largely been found to imagine a future with work outside the home than girls whose fathers were not engaged in household chores (Croft et al., 2014, p. 1426). In this light, men's care for their households and partners at the time of pregnancy and the coinciding edges of emergent masculinities and involved fatherhood norms could be conceptualised as a small piece in an intergenerational investment in future gender norms, harnessing slow but steady modifications towards dismantling the unequal gender system.

6.2 Methodological discussion

In this section, I give an account of methodological rigour and trustworthiness of the approaches adopted in the conduct of this study. I reflect on the strengths and weaknesses of the study

drawing on the concepts of credibility, dependability, transferability, and reflexivity enunciated in the qualitative methods literature (Green & Thorogood, 2018; Mays & Pope, 2020; Yilmaz, 2013).

6.2.1 Credibility

A study is said to be credible when the study follows established research approaches within the field and communicates the study's findings in a manner that does not distort or misrepresent the participants' views (Graneheim et al., 2017, p. 33; Nowell et al., 2017, p. 3). Qualitative research experts have outlined a number of ways that researchers can enhance credibility, including prolonged engagement with the study setting and participants; persistent observation; triangulation of methods, participants, and investigations; peer debriefing; and member checking (Morse, 2018, p. 801; Nowell et al., 2017, p. 3). The purpose of prolonged contact with the field is to enhance the presentation of rich descriptions of the study context (Green & Thorogood, 2018; Nowell et al., 2017; Yilmaz, 2013). In this study I strove to reach these ideals, albeit some weaknesses remained, and these will be addressed in the next few paragraphs.

As part of the conduct of this study, I engaged in observation at health facilities, the Sakora community, and some participants' homes in Accra. Before this study, I had no knowledge of Afram Plains. I read information available about the district on the internet and paid two preliminary visits during which I held general conversations with various gatekeepers, including the District Health Director, chiefs, elders, and local government representatives. The preliminary visits were followed by one month of observation. The village has a small population, which facilitated observation of how daily lives and social activities were organised and structured.

Observations in Accra were mainly limited to the health facility. As mentioned in Chapter 4, I planned to interview the Accra male participants in their homes and also use that as a chance to see their household arrangements, and possibly observe what tasks men carried out in the home. The few visits to participants' homes for interviews made it clear that this procedure did not present a natural environment for our interaction. I observed that participants experienced discomfort and sometimes lost concentration during the discussion, and thus I had to cancel visits to participants' homes as part of the research approach. However, during the second data collection period, I interviewed participants at their homes and visited some of them subsequently for informal talks. The inability to conduct more observations in participants' homes in Accra implied that narratives, reflections, and accounts of practices in the domestic arena might not equal to actual practices in their daily lives.

Another criterion for strengthening the credibility of qualitative studies is triangulation of methods, participants, and analytical frameworks (Lewis et al., 2014; Mays & Pope, 2020; Nowell et al., 2017). I used semi-structured interviews, FGDs, observations, and informal conversations to gather data. The methods supplemented each other in a manner where I believe I gained more clarity on topics in the sense that data collected through one method (for example, interviews) would continuously either confirm or problematise data collected through another method (for example, observations). A vital benefit of using different methods in this study relates to the engagement of men in Sakora. In interviews, men's accounts were mostly scanty, and I had to use probes intensively to access in-depth descriptions. However, in the one FGD with men in Sakora, they influenced each other and discussed their personal lives more openly in a natural and conversational manner with minimal involvement from me.

Yet, FGDs presented two challenges in the conduct of this study. First, I conducted all FGDs in this study alone, playing the double role of a facilitator and a note taker. Thus, I sometimes missed the non-verbal communication, facial expression, and body language of group members,

thereby weakening the credibility of the FGDs as highlighted in the methods literature (Hennink, 2014). Secondly, FGDs presented ethical dilemmas in both Accra and Sakora. Some women in FGDs in Accra were acquainted with each other. Sakora presented a more complex scenario since it is a small community and all participants knew each other. Thus, it is impossible to account for the potential breach of confidentiality of the personal disclosures made in FGDs.

Triangulation was enhanced by engaging a variety of participants comprising fathers, mothers, health workers, and background informants to reflect on the same topics under study. The findings from different study participants provided corroborating and crosscutting accounts that enriched the depth and understanding of the data material. For example, participants in both urban and rural areas talked about love and mutual understanding between partners as an element of masculinity and fatherhood. This enhanced triangulation improved my ability to discuss the concept of emergent masculinities in the peer-reviewed articles.

The inclusion of a group of women and one health volunteer in Sakora presented a potential drawback. As mentioned in Chapter 4, I gained access to the Sakora community with the assistance of PLAN Ghana in anticipation that I would collect data from one of their project sites. The community was at the time of my fieldwork about to launch the SHOW Project and had trained health volunteers and support groups who were members of the community. I engaged one of the trained health volunteers and a group of four mothers (mother support group). It emerged that their training for the SHOW Project influenced some of their reflections. Although the findings from these interviews and FGDs have mostly not been included in the peer-reviewed articles, I cannot completely know how the initiation of the project overall influenced the data that I gathered in the community.

Triangulation was further strengthened through the appropriation of different frameworks of gender analysis to interpret and conceptualise the accounts of the study participants. The peer-reviewed articles drew on three sets of theories of gender in the field of sociology, that is, theories of masculinities including postcolonial perspectives; conceptualisations of space, place and gender; and the theories of 'doing' and 'undoing gender'. Incorporating these sets of theories provided nuanced interpretations of participants' accounts and enabled the study findings to make connections with other studies.

The qualitative methods literature also highlights peer debriefing and member checking as ways to enhance credibility (Morse, 2018; Nowell et al., 2017; Yilmaz, 2013). In an attempt to incorporate peer debriefing, I presented pilot findings immediately after fieldwork to colleagues at the University of Bergen to test preliminary interpretations. For example, I presented the concept 'escorts' and showed data samples that related to this term. From the subsequent discussion, it emerged that the term could be interpreted in two ways, that men saw themselves as 'escorts' with little to contribute at the clinic and/or that they were willing to be more involved in the clinic's activities but were perceived as 'escorts' by health workers.

Member checking was very limited because not all men were included in the study after they had become fathers. Only five selected Accra male participants who had become fathers were interviewed again after almost a period of one year. In these interviews, men were asked again to reflect on their visions of fatherhood as they had in the first interviews when they were expectant fathers. The interviews also collected men's fathering experiences and practices, the changes in their intimate relationships and social status, the decisions they made and their struggles as new parents. However, the data from these interviews have been incorporated only to a limited extent in the peer-reviewed articles and thus, this thesis has missed the opportunity to discuss the Accra male participants' fathering experiences.

It has increasingly become expected of qualitative researchers to discuss the influence of language translation as part of accessing the credibility of a study (Roth, 2018). My study is an example of what has been referred to as cross-language research (Erhard et al., 2021; Ho et al., 2019; Macht, 2018) since I conducted many of the interviews and FGDs in Twi, which were translated and transcribed into English. The literature on cross-language qualitative research shows that translated transcripts can potentially lose the original meaning of texts due to the difference in sentence structures and cultural influences on meaning in various languages (Ho et al., 2019, p. 2; Macht, 2018). Furthermore, qualitative research experts have indicated that the socio-cultural background of translators can influence how they use and understand words, phrases, and terms (Erhard et al., 2021, p. 5).

To conduct this study, I used a research assistant to transcribe and translate the audiotapes of the interviews and FGDs. He is fluent in Twi and English and has an educational background in the study of linguistics. Upon receiving the transcribed and translated files, I audited all transcripts in order to ensure that the use of terms, phrases, and words was consistent in the translations. The use of cross-language in this study implies potential weaknesses similar to the challenges indicated in the qualitative literature (Macht, 2018; Roth, 2018). It is likely that both the research assistant and I translated the audiotapes based on our socio-cultural backgrounds. Thus, the meanings of study participants' words, phrases, and terms could be slightly different from what is described in the peer-reviewed articles and as a consequence, the study may have read meanings and interpreted portions of the data in ways that do not convey exactly what the study participants had implied.

6.2.2 Dependability

Another way of improving trustworthiness in qualitative research is by scrutinising the study in terms of dependability, which is described as facilitated by providing a "logical, traceable and

clearly documented" research process (Graneheim et al., 2017; Graneheim & Lundman, 2004; Nowell et al., 2017, p. 3). This process has been noted as necessary in order for readers to assess the dependability of the conclusions based on the methods used, participants engaged, and coding procedures utilised by the researcher (Mays & Pope, 2020; Morse, 2018; Yilmaz, 2013). To improve dependability in this study, I have attempted to describe and justify the choice of research design, the selection of study sites, and recruitment of participants. In addition, samples of the information letters and interview and FGD guides have been recorded and are available for readers in Appendices II through VI. Furthermore, I have attached a sample of my analysis, which exhibits data extract, codes, sub-categories, categories, and themes, in Appendix VII.

It should be noted that interview and FGD guides were constantly adjusted through the research process. As indicated in Chapter 4, I decided to conduct FGDs for community health nurses (CHNs) although doing so had not been planned, and I adjusted the interview guide for health workers for this FGD. Similarly, I adjusted the interview guide for expectant fathers to facilitate a FGD for men in Sakora. Moreover, questions were changed in the guides and new questions added throughout the research process, and therefore the questions in the guides attached to this dissertation were not necessarily used verbatim in every situation.

6.2.3 Transferability

Transferability addresses the vital question in research concerning the extent to which the findings of the study can be generalised to other groups in the same population or a different setting (Green & Thorogood, 2018; Lewis et al., 2014; Nowell et al., 2017). Malterud (2001) acknowledged that no qualitative study can provide findings that are universally applicable. However, the objective of all research is to provide findings that can be extrapolated beyond the study setting (Malterud, 2001). To boost transferability, researchers are expected to provide rich contextual descriptions, compare results with other studies, and adopt theoretical

frameworks that permit inferences to be generated from the data (Green & Thorogood, 2018; Nowell et al., 2017).

The study was carried out at only two research sites, one hospital in Accra and one village in Afram Plains, and with very few participants. Still, I have tried to provide a rich description of the research settings and study participants, integrated theories of gender in the fields of sociology and feminist geography, and incorporated existing literature to enhance readers understanding of the research findings. Notwithstanding the (small) size of the study, the discussions underscored in this dissertation can contribute to the scholarship on men's roles during pregnancy and the construction of complex norms of masculinities and fatherhood among young men in Ghana and Sub-Saharan Africa.

6.2.4 Reflexivity and the researcher's role

Mays and Pope (2020, p. 219) have defined reflexivity as "sensitivity to the ways in which the researcher and the research process have shaped the data collected, including the role of prior knowledge, assumptions and experience, which can influence even the most avowedly inductive enquiries." A researcher's linguistic background, age, gender, marital status, educational background, sexual orientation, personal experiences, moral beliefs, political affiliation, and theoretical knowledge can influence the formulation of research questions, data collection, data analysis, and the dissemination of results (Berger, 2013; Malterud, 2001). A researcher's socio-cultural background similarly influences his/her positioning in relation to the 'insider'/'outsider' dichotomy, which can affect what the researcher is able to observe, understand and document (Adeagbo, 2021; Berger, 2013; Maharaj, 2016, p. 117). To enrich trustworthiness in qualitative research, it is important that researchers account for ways in which their backgrounds, beliefs and values have affected research procedures (Berger, 2013; Malterud, 2001; Mays & Pope, 2020; McHugh, 2014). In the following paragraphs, I provide

some reflections on how my social and educational background may have influenced this study and my movements between the 'insider' and 'outsider' positions.

I am Ghanaian and had lived in Accra for about 15 years prior to the study, and had worked on various reproductive health projects that involved collecting data at health facilities in the city and in rural communities. My shared identity and interest in the topic area positioned me as an 'insider' vis-a-vis my study participants. I had a relatively good understanding of the social context in Accra and knowledge of how hospitals such as the one selected for the study operate. My knowledge of the research setting was useful in the design and selection of study sites and study participants. However, my preconception of the operation of health facilities like the selected hospital and the role of health workers may have influenced the formulation and structure of the interviews and FGDs. Moreover, my observations may have been blurred and biased in a way that may have led me to omit important details at the clinic that a researcher who was unfamiliar with the context would have recognised.

Interactions with men and women in Accra were mostly informal, relaxed, and conversational. This may, I think, again be related to my position as an 'insider' and my ability to establish rapport through small conversations during recruitment and phone calls with participants prior to interviews. Informal relationships were further developed with participants that I remained in contact with and interviewed after the birth of their children. The second round of interviews were even more relaxed and conversational, as mentioned in Chapter 4. Moreover, participants became open to my visiting their homes. My educational background, a young woman schooling abroad, however, established me as an 'outsider' and influenced the responses and behaviours of participants at times during the first phase of data collection. In Accra, participants often compared and contrasted Ghana to Norway in interviews and sometimes implied distrust in my ability to understand their perceptions about social relations in Ghana, since I was schooling abroad.

The researcher-researched relationship in the village mostly worked better than anticipated because of my age category, which was similar to the age of most study participants, and my ability to speak the two local languages (Twi and Ewe) spoken in the community. The Sakora village had substantial similarities with my native village, and hence, I knew and observed the expected hierarchies in speech and social relations and blended effectively into the way of life in the community. However, my assumed knowledge of the community created a disadvantage, as I may have been unable to see and note beyond what I knew and expected.

The discussions and interactions with women in Sakora were relaxed and conversational, but men initially maintained a quite formal relationship with me. The 'outsider' position effect seemed strongest among men in Sakora where the only shared identity I had with men was that I am Ghanaian and able to speak their language. I speculated that they were uncomfortable speaking alone with a young woman from Accra. As I continued to engage men in informal talks, I gradually developed informal relationships with men in the community. The evolved informal relationships, I believe, encouraged a group of men whose partners had already been engaged in the study to request their own FGD. It appeared that FGDs generally created an environment where I became less visible in relation to group members. Hence, participants became more interested in reflecting on the topics under discussion rather than paying attention to my personal background.

I began this research and fieldwork with preconceived assumptions about sharp disparities in socio-economic and cultural situations between urban and rural Ghana that I thought would provide for different gender relations between the two settings. Although the economic contexts in the two selected locations were different, the data revealed other nuances and was more complex than I had expected. For example, rural-urban socio-cultural differences did not generate strikingly different findings as projected related to gender norms in the household during pregnancy. Moreover, since the Afram Plains geographically belonged to the Kwahu,

an Akan and a matrilineal lineage group, I was expecting to find corresponding social practices and its influence on gender norms. I was however surprised to find that the Sakora village was a largely migrant community with diverse ethnicities. For this reason, the study's discussion has been unable to draw conclusions based on ethnic or lineage affiliations.

During the first fieldwork, my inexperience of pregnancy and childbirth worked well to position the research participants in terms of being more knowledgeable about the research topic and questions than I-the-researcher am. From previous research experience and working in the field of reproductive health in Ghana, I anticipated this position of an 'outsider' in terms of the experience of pregnancy and childbirth and drew on it to encourage participants to educate me on the subject matter. At the time of the second interviews, I became an 'insider' since I was expecting a child. This new position changed my relationship with the study participants and influenced how I interpreted and discussed portions of the data.

Men shared their stories referring to my condition, expecting that I understood their accounts and would be more empathetic. Sometimes, participants paused and asked whether I agree with them or understand their concerns, placing me in a somewhat ambiguous situation and I did not know how to react. Initially, I could not understand why some women preferred to attend maternity care services without their partners until I received antenatal and postnatal care in a public health facility in Accra. I experienced the impatience of mothers in the waiting area of the clinic and the unfairness of having mothers attending care with their partners jump the queue simply because a man accompanied them. These experiences drew me closer to the research and informed some of the articulations underlined in this study.

7 Conclusion

This study set out to contribute to the empirical and theoretical discussions of the gender-transformative potential of men's involvement in the care for their pregnant partners, norms of involved fatherhood, and the development of non-dominant masculinity in Ghana and Sub-Saharan Africa. The study has attempted to provide a nuanced understanding of the complex co-existence of multiple masculinities and the expansion of men's roles in the domestic arenas, especially during the time of pregnancy, in Ghanaian contexts. It has additionally attempted to explore conceptually how the spatial construction of the maternity clinic was endowed with empowering possibilities for pregnant women but generated potential drawbacks to the engagement of men who accompanied their partners to ANC. Moreover, it was important that men's voices, narratives, and reflections, as expectant and experienced fathers, formed the bulk of the research material. The men and women who participated in the study lived in both rural and urban areas, and very few of them had completed tertiary education. The accounts and narratives explored in this study represent gender norms and practices in households from multiple layers of the society.

As illuminated in this study, men's roles during the time of pregnancy are multifaceted, varied, and dependent on what men and women find valuable. In rural areas, men provided financial resources, increased the performance of housework, took up most of their partners' farm work, and assisted with adherence to recommended health regimes. Men in urban areas also intensified their participation in domestic work, provided financial resources for their pregnant partners, and participated in ANC services. The roles outlined here indicate that during the time of pregnancy, masculine acts that do not undergird the subordination of women can be discerned.

The study demonstrates that in both rural and urban contexts, norms of involved fatherhood and emergent masculinities are found among the young fathers studied, alongside the existence of hegemonic masculine norms. However, involving men in pregnancy-related care, especially in the delivery of health services, remains a dilemma. Including male partners in ANC services could encourage men to ally with women and become equally responsible for maternal and neonatal care. Conversely, involving men could destabilise a core source of women's symbolic power and weaken women's abilities to freely discuss their health, furthermore limiting their social connections with other expectant mothers.

Men and women's opposition to making the performance of housework a permanent part of male responsibilities in the family setting signifies a fundamental challenge to long-term modifications in conventional gender norms and practices. Men's expanding roles during the time of pregnancy, including the intensive engagement in household chores, may bolster the development of involved fatherhood norms and emergent masculinities without radically altering structures that underlie unequal gendered power relations. Yet the additional roles that men take on in the care for their pregnant partners and households represent an enactment of gender relations that transcends the asymmetrical differences embedded in the male breadwinner/female domestic-caregiver model.

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ARTICLE I

Our material suggests that men are increasingly expected to share housework, care for their children, and at times spend "quality time" with their partners and children.

Making Fathers: Masculinities and Social Change in the Ghanaian Context

Gloria Abena Ampim, Haldis Haukenes, and Astrid Blystad

Framed within recent debates about hegemonic masculinity and in-depth historical and contemporary research on fatherhood and gender roles in Ghana, this article explores current ways of becoming and being a father in Ghana. Existing studies of fatherhood and masculinities in Ghana tend to present men in conjugal unions as patriarchal and dominating over their wives and children and fatherhood as related mainly to breadwinning and demonstrating sexual potency. Through observation studies, semi-structured interviews, and focus-group discussions with fathers from urban and rural contexts, this article explores multiple ways of achieving masculinity through fatherhood and ways in which new fathering ideals and expectations come to be incorporated into local gendered ideals. It suggests that alongside values of providing for their families, ideals of involved fatherhood emerge among the study participants, indicating early signs of a shift away from established sociocultural gendered expectations of hegemonic masculinity.

Introduction

Gendered expectations in Ghana define men as leaders and providers and women as homemakers (Adinkrah 2012, 2017; Adjei 2016; Adomako Ampofo 2001; Adomako Ampofo and Boateng 2007; Boateng et al. 2006; Lambrecht 2016; Nukunya 2016; Oheneba-Sakyi 1999). The male breadwinner ideal in Ghana, although still upheld, may not reflect the lived experiences of couples, as more and more women play large roles in providing for their families (Boni 2002; Clark 1999; Kwansa 2012; Tolhurst and Nyonator 2006).[1] Women are increasingly working long hours outside the home, and the separation from kin due to rural–urban migration has created a gap in kin support for childcare in urban Ghana (Badasu 2004, 2012; Oppong 1980,

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2004, 2012; Wærness 2012). Little, however, is known about what has happened to fathers' roles and expectations in the household as mothers' roles have expanded. Are fathers expected to perform additional roles, and what do fathers themselves perceive about these roles? The few available Ghanaian studies discussing changes in fatherhood norms have focused solely on urban areas (Fernández-Cornejo et al. 2019; Ganle 2016; Kwansa 2012). Studying the current expectations of fathers in Ghana provides an opportunity to consider fathers' potential appropriation of new norms and a chance to look at tensions arising between new fathering norms and dominant ideals of masculinity in non-Western contexts. With views from both urban and rural fathers, we here explore current ways of becoming a father and how ideals of fatherhood intersect with constructions and enactments of masculinity. We draw on theoretical perspectives in R. W. Connell's classical works on hegemonic masculinity and works that have criticized and further developed this line of thinking in fruitful and dynamic ways.

Hegemonic and Emergent Masculinities

Hegemonic masculinity as a conceptual framework was developed in the 1980s by Connell (1987, 1995), who 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" (1995, 77). This theorization of hegemonic masculinity concerns relationships not only between men and women, but also among men, not all of whom enact the dominant ideal of hegemonic masculinity: those unable to live up to it may produce subordinated models, which could be aligned with femininity (Connell 1995, 78), or they may be marginalized from hegemonic masculinity by age, class, race, and ethnic affiliation (Connell 1995).

Connell's concept of hegemonic masculinity has influenced much research on men, gender relations, and hierarchy in the social sciences over the past three decades. It has been subjected to substantial criticism. Postcolonial scholars have criticized it for its failure "to recognize historical and cultural situations within which several hegemonic forms of masculinity may co-exist" (Miescher 2003, 89). African gender relations have been described as a "patchwork of patriarchies, both colonial and local" (Lindsay and Miescher 2003, 3). It has been argued that precolonial African societies had multiple ways of being a man, and that, with the advent of missionaries and Western education, new ideals of masculinity were introduced into an already complex masculine world. The interaction between precolonial and colonial masculinities in turn produced multiple dominant masculinities, in a manner where none of them successfully displaced the others (Miescher 2003, 2005, 2007).

Responding to criticism, Connell and J. W. Messerschmidt (2005) called for a conceptual review that would account for other forms of gender hierarchies, with more attention paid to contexts and geographical location in

constructing masculinities. Marcia Inhorn and Emily Wentzell, picking up on this call for "theoretical reformulation," introduced the concept of emergent masculinities in an attempt to move away from a primary focus on hierarchy and domination (2011, 803). They constructed the term on the basis of Raymond Willams's notion of emergence (Williams 1977, quoted in Inhorn and Wentzell 2011, 803)—in other words, "new meanings and values, new practices, new relationships and kinds of relationship which are continually being created" in societies. The concept accounts for "new forms of everyday masculine practice" that accompany social change, but also acts of manhood as they change with contexts—marriage, fatherhood, employment—and over the course of life (Inhorn and Wentzell 2011, 803; see also Inhorn 2012, 31).

Involved fatherhood, defined as "an ideal of emotionally present and nurturing father" (Farstad and Stefansen 2015, 55; see also Magaraggia 2012; McGill 2014) can be described as an expression of emergent masculinities (Inhorn 2012). Ideals and practices of involved fatherhood, mostly researched in Western contexts, do not indicate a rejection of the widely held breadwinner ideal (Farstad and Stefansen 2015); rather, they represent an expansion of men's roles in parenting to include more emotional involvement and physical caregiving. Involved fatherhood could, therefore, be seen as a form of masculinity that men enact in their marriage and family life in a manner that does not necessarily protest or oppose hegemonic ideals, but expands men's roles to include previously defined "feminine" tasks (Inhorn and Wentzell 2011).

The notion of hegemonic masculinity helps make sense of dominant ideals emerging from the narratives of our study participants; however, the ideals are explored with the awareness that different dominant ideals may coexist, as suggested by Stephan Miescher (2003, 2005, 2007). Inhorn and Wentzell's concept of emergent masculinities is relevant when exploring traces of new and novel elements of masculinity in participants' narratives of being and becoming fathers.

Fatherhood and Masculinity Studies in Ghana

A study that explores signs of potential transitions in ideals of masculinity and fatherhood will benefit from a brief historic contextualization, and we review some historical studies before we move to scholars' analysis of the contemporary situation.

Historical studies of fatherhood and gender relations in marriages give opposing accounts for matrilineal and patrilineal societies in Ghana. The matrilineal Akan gender relations before colonialism have been presented as quite gender equal, in that women and men had fairly similar social and political responsibilities (Oppong 1980). After marriage, women remained part of their lineage, and children belonged to their mother's lineage in a manner that is characteristic of matrilineal societies (Nyarko 2014; Oppong 1980; Rattray 1923). Fathers exercised authority over their sisters' children, rather than over their own children. Therefore, mothers promoted

special bonding between their children and their matrikin (Nyarko 2014). Nonetheless, paternity remained a significant aspect of social life and status in the Akan matrilineal system (McCaskie 2015; Nukunya 2016).

Studies from patrilineal societies from both precolonial and colonial times show a clearer distinction of roles between men and women. A father protected his wife and provided the wife and children with a home, food, and medical care (Fortes 1949, 101; Nukunya 2016), while the wife was responsible for cooking, fetching water, and childcare (Fortes 1949, 101; Nukunya 2016). Husbands were entitled to marry more women (with the consent of their first wives) and could punish their wives physically. At the same time, a husband was expected to treat his wife with love and kindness, regularly give her gifts, and pay her debts (Nukunya 2016, 59).

Miescher's (2003) historical study from matrilineal Kwahu suggests three precolonial dominant masculinities: adult masculinity, senior masculinity, and the big-man status. Having biological children and performing the roles of a father, such as providing for a wife, children, and kin, were significant in attaining all three dominant masculine ideals (Miescher 2003, 2007). Adult masculinity was reached by marrying and performing tasks such as taking care of a wife or wives and children and providing support for external kin. Senior masculinity was achieved through an individual's conduct in society, the ability to speak well in public, to mediate conflicts, and to provide advice (Miescher 2007). Finally, the big-man status, also common in other parts of Africa, was based on wealth, number of wives, and the number of people a man supported (see also Barker and Ricardo 2005; Dover 2005; Obeng 2003).

Cocoa farming, Christian marriages (or the marriage ordinance introduced by the British in 1884), and Western education have been identified as key elements in disrupting Ghanaian social life (Nave 2016; Nukunya 2016; Oppong 1980). In colonial Asante, for example, women challenged the matrilineal inheritance system by asking for portions of their divorced or deceased husbands' estates because of their contributed labor to cocoa farming (Allman 1991, 1996). Marriage by ordinance meant, for instance, that children, rather than nephews and nieces, inherited from parents (Nukunya 2016; Oppong 1980; see also La Ferrara and Milazzo 2017). Structural-adjustment programs of the 1970s and 1980s have been found to influence men's ability to provide for their family's upkeep (Clark 1999; Overå 2007). Urbanization and the lack of kin support for childcare and domestic duties in the urban areas further increased women's burdens as mothers and wives (White et al. 2005; see also Badasu 2004, 2012; Kwansa 2012; Oppong 1980, 2012).

Moving back to the question of masculinity and fatherhood, contemporary Ghanaian studies have asserted that the ability to impregnate a woman is a key element for a man to prove his masculinity. Mary Owusu and Lawrence Bosiwah's (2015) contemporary oral historical study, conducted among Fante-speaking Akan, for example, demonstrates that Fante men first and foremost equated masculinity with the phallus and sexual

performance. Preparedness, protection, defense, authority, and common goodness were mentioned as additional symbols of masculinity (Owusu and Bosiwah 2015, 136). A study conducted in Accra with men from different ethnic backgrounds similarly revealed the centrality of biological fatherhood to masculinity (Adomako Ampofo, Okyerefo, and Pervarah 2011). Participants linked biological fatherhood to phallic competence, but more broadly to adulthood and responsibility.

Several contemporary Ghanaian studies from matrilineal and patrilineal societies have argued that Ghanaian men continue to be socialized to exercise patriarchal domination over their wives and intimate partners (Adinkrah 2012, 2017; Adjei 2016; Adomako Ampofo, Okyerefo, and Pervarah 2011; Fiaveh et al. 2015; Oheneba-Sakyi 1999). Customary Ghanaian marriage in patrilineal and matrilineal societies requires the payment of a bride price by the man to the woman's family. The bride price can involve cash or substantial material goods, including cattle, jewelry, and cloth (Adinkrah 2017, 5). It is argued that men commonly regard the payment as an act of purchase, which entitles them to ownership of their wives (Adinkrah 2017; Coe 2012).

The literature reviewed above demonstrates both changes and continuities in gender roles and ideals of masculinity. The gendered division of waged and household labor is transforming, but little is known about its potential implication for the ways in which Ghanaian men conceptualize and practice fatherhood and how current fatherhood ideals interact with precolonial and colonial masculinities and gender arrangements. In our study, we explore continuities and changes in ideals of fatherhood and masculinities in an urban and a rural context in Ghana. Using our research with men living in Accra and in a rural area in the Afram Plains North District, we investigate the mutual formation of fatherhood and masculinity and compare the perceptions and experiences of men from the metropolis with the views of farmers and artisans from the countryside.

Study Context

The study was conducted in Accra, Ghana's capital, and in a village, given the pseudonym of Sakora, in the Afram Plains North, located in the Eastern Region of Ghana. According to the national population census conducted in 2010, Accra has more than four million residents (Ghana Statistical Service 2013). Its population consists of diverse ethnic groups, including Akan, Ewes, Gas, Dangme, Guan, Gurma, Dagbani, Grusi, and Mande. The 2010 census showed that the extended family structure was becoming less common in Accra, with most households consisting of spouses and biological or adopted children. Only 39 percent of the population was married; the rest were either cohabiting, single, widowed, or divorced. The fertility rate in Accra was approximately 2.5 (Ghana Statistical Service 2013).

The other study context is located in the Afram Plains North, which has a population of about 102,000 and where 86 percent of the area is rural.

The general fertility rate in the district is 4.2 (Ghana Statistical Service 2014). Although the Afram Plains is geographically located in Kwahu land, the residents of the Afram Plains North are from the Volta, Northern, Eastern, and Ashanti regions and belong to diverse ethnic groups. The community depends on farming and fishing; 70 percent of the labor force is engaged in skilled agriculture, forestry, and fishery (Ghana Statistical Service 2014).

Monogamy, polygamy, and informal conjugal unions are all widespread in Sakora. Informal conjugal unions often result from the not uncommon scenario of a young girl becoming pregnant out of wedlock. Because these unions are initiated at a young and economically unstable age, the partners in question often do not live together, not even after the child is born, and these unions easily break up; however, the general norm is that married couples should live together in privately owned (small) houses.

Study Participants and Methods

This article forms part of a larger ongoing qualitative study, which explores the links among patriarchy, gender relations, and male involvement in maternal and infant healthcare. For the broader study, the first author conducted interviews and held focus-group discussions with mothers and health workers, in addition to engaging with expectant fathers. This paper focuses only on the fathers and is based on interviews, a focus-group discussion, and observation.

Study Participants

In Accra, study participants were recruited through the maternity unit and child-welfare clinic of a key government hospital in Accra. In Sakora, participants were recruited with the assistance of health-service providers at the Community Health-Based Planning Services compound, where the midwife and nurses introduced the first author to expectant mothers in the community. Partners of these mothers were subsequently recruited for interviews. Participants for the focus group were recruited by the first author. The initial criterion for inclusion in the study was being a first-time expectant parent living together with one's spouse. The criterion worked well in Accra. In Sakora, however, many first-time expectant mothers and sometimes fathers were teenagers who lived apart from their partners. Thus, with the exception of one participant, expectant fathers recruited in Sakora already had children.

The Accra fathers (eleven) were aged between twenty-eight and thirty-nine and had education levels ranging from the completion of junior high school to tertiary school. All participants in Accra were living with their partners, expecting a child, and living in a nuclear family structure. All the Accra fathers and their partners worked outside the home, either in the informal sector as traders and artisans, or in the formal sector as teachers, sales personnel, or civil-service administrators.

The Sakora fathers (twelve) were aged between twenty-one and forty-eight, and educational backgrounds ranged from the completion of primary school to senior high school. With the exception of one expectant father, who lived separately from his partner, all participants lived with their partners in nuclear family structures. The men worked as farmers. Two participants supplemented farming with the provision of motorcycle transport services.

Participants in Accra and Sakora came from either of the patrilineal and matrilineal groups that constitute the two main lineage systems. They represented four main ethnic groups: matrilineal Akan (Kwahu, Fante) and patrilineal Ewe, Dagbani, and Guan.

Data Collection

The data gathering for this study began with observation, conducted over a seven-month period at the selected hospital in Accra to learn about men's interactions during antenatal, postnatal, and child-welfare services at the clinic. The first author observed daily activities at the maternity unit and child-welfare clinic of the selected hospital and visited couples in their homes to observe their activities and household arrangements. Participants in Accra were recruited during observation at the hospital.

Observation was conducted for one month in Sakora to learn about fathers' everyday life and practices, as suggested by Paul Atkinson and Lesley Pugsley (2005). In Sakora, the first author visited couples' homes daily, participated in communal meetings, and stayed with women at the market. Men were engaged in informal conversations in the evenings, when they had returned from the farm and were relaxing under trees by the roadside. These interactions provided insights into practical daily activities of men and women in the village.

Semi-structured interviews were conducted with eleven fathers in Accra and six fathers in Sakora. The researcher encouraged fathers to tell their own stories about fatherhood and masculine ideals. Additionally, one focus-group discussion was conducted with six fathers in Sakora to learn about their perceptions and understandings of fatherhood and the expected roles of fathers and to gain insights into current fathering practices as expressed in the group. Interviews and discussions were conducted in English and Twi. In Sakora, the interviews took place in the home of participants, while the focus-group discussion took place at the community square. In Accra, interviews took place at the hospital, at participants' homes, and at other meeting places in the city.

Data Analysis

All interviews were audio recorded. Audios were transcribed and stored in a QSR NVivo software database. Data were analyzed thematically, based on Virginia Braun and Victoria Clarke's (2006) six phases of analysis. Themes

were generated from latent meaning, assumptions, and conceptualizations of the data, and from questions such as "When does fatherhood begin?," "What are the most important roles of fathers?," and "What makes a good father?"

Ethical Considerations

The study team obtained research clearance from the Norwegian Institute for Data Protection (53570/3/ASF) and ethical clearance from the Ethical Review Committee of the College of Health Sciences, University of Ghana, Legon (CHS-Et/M.6–P1.12/2017–2018). Additionally, the authors sought permission from the selected hospital in Accra and from the Afram Plains North District Health Directorate. Written or oral informed consent was obtained from all participants after the purpose of the study had been thoroughly explained (Kvale and Brinkman 2009). Data were anonymized upon transcription and saved on a password-protected computer.

Study Limitations

The study is limited regarding the different categories of men that were recruited from the two study sites. It was easier to recruit first-time expectant fathers in Accra than in Sakora. Indeed, with one exception, all participants in Sakora had already had the experience of fathering. Although the topics covered in the focus-group discussion and interviews were the same, participants in Sakora at times responded based on their own experiences of fatherhood, while participants in Accra responded based on their expectations and general knowledge.

Fathers from Accra were recruited at the hospital because of the aim of the larger project—to explore fathers' experiences of maternal- and infant-welfare services. Men do not commonly participate in antenatal care, and therefore it is possible that the men who participated were not representative of "ordinary" Ghanaian men; however, these men were not from a particular or singular social background, but were artisans and retailers, with only two of them working in the formal sector as sales and marketing officers.

Another limitation concerns the type of material that forms the basis of our study. This is a qualitative study, which by its nature is explorative and in depth, but limited in scale and scope. Our data consist primarily of (expectant) fathers' narratives, their reflections on fathering ideals, and their accounts of their own behavior in the family, with limited observation in the family setting. These narratives do not equal practices: what (expectant) fathers say they (will) do may be far from how they actually perform their roles in daily life. Hence, the study is indicative of changes at a normative level only.

Fatherhood in Accra and Sakora

Fathers who participated in this study seemed to phrase their notions about masculinities and fatherhood ideals in terms regarding different stages of the life course. These views were irrespective of their ethnicity or lineage, and hence the findings are organized according to the stages that the men narrated. The stages involve perceptions about becoming a father and being a father.

Becoming a Father

Transitioning from Boyhood to Adulthood

In both Accra and Sakora, behaving like a responsible adult man was mentioned as the first step toward fatherhood. It was argued that once a young man began considering fathering a child, he started to prepare financially and abstained from behaviors such as promiscuity and excessive drinking. Entering into this stage often implied marriage or cohabitation with a chosen female partner. Eddie, a twenty-eight-year-old man who had been cohabiting with his girlfriend in Accra for ten years, was expecting their first child and spoke about his transition to becoming a father:

> As a man when you get to a certain age, you should be careful and think about the future. For instance, if you are eighteen years old, and you have about four girlfriends, you do not need to be told that it is not a good thing. Because if they all get pregnant, how will you be able to take care of all of them and the kids that come? A father is one that can sit down and think about the future and plan well how to execute his responsibilities.

Kojo was twenty-seven years old. He lived in Sakora with his wife and two children. He ended formal education after junior high school, traveled to the mining regions of Ghana, and worked as a laborer for a few years. He made some money at a young age and later returned to his village, where he kept multiple sexual partners and spent his money with friends. He was now working as a farmer and a motorcycle transport service provider. He talked about his transition to adulthood in the following way:

> You know, sometimes when you get to a certain stage in your life, you know that there is a need to change some things in your life. One such change is marriage. Upon a good thought, you would know that the money would have been used to do something productive if you have a wife, so it is a motivation in disguise.

Kojo's narrative highlights marriage as an important marker in a boy's journey to adulthood, ensuring a more productive use of resources. Sometimes, advice from men's own fathers is important in the decision to marry. Kojo continued:

> I spent a lot of money before, wasted it on women, wasting money on drinks, and having fun with friends. Because of that lifestyle, I could not stay with only one woman. I even have a child with one woman I did not marry. I used to change women. However, luckily for me, my father called me and advised me to get a wife. I thought about it. We stayed together for about four years, though, before we married.

Elorm was a thirty-year-old artist who lived in Accra with his eighteen-year-old fiancée. They were expecting their first child. According to Elorm, his father advised him to delay pregnancy until he was economically independent:

> He [father] told me as a man if you do not have your own room and job, you should not think about a woman because when you try and impregnate someone's child [someone = the girl's parents] and you are not ready to take care of her, you will be humiliated.

For participants in this study, the first step toward attaining adult masculinity is thus economic and social preparedness, followed by the stage of marriage or cohabitation. Boys are expected to learn the rules in preparation for each stage and become competent. If they do not prepare adequately, they may fail and experience humiliation, as several participants indicated.

Fatherhood as Providing for Partners and Kin

A widespread idea among our study participants was that adult males might practice fatherhood before becoming a father—by providing for their wives, kin members, and other children in the community. This notion of fatherhood was more evident in narratives from Accra than in those from Sakora. Many young men in Sakora became biological fathers before they reached what can be called responsible adulthood. Meanwhile in Accra, men mostly aimed to achieve the status of a solid provider before biologically fathering children. According to Elorm:

> I think fatherhood starts when you start taking care of your woman. Because if you can take care of your woman, it means you can take care of your children, too. If you cannot care [provide] for someone, then you are not a father. There are men, but those who wake up and take care of others are those who deserve to be called fathers.

Joseph was a thirty-two-year-old sales officer who was cohabiting with his fiancée, and they were expecting their first child. He shared similar views about how "fathering" his partner motivated the pregnancy:

> Fatherhood starts from the stage where the couple is living together. Because the woman must see that you can take care of her child. So if you show care for the lady while living together, she becomes comfortable to allow you to even impregnate her. There are many women who get pregnant and abort it because they don't want the man to be the father of their child. For instance, she wanted to get pregnant with me earlier, but I insisted that my religion does not accept that you would get pregnant before getting married. Even when she got pregnant, I wanted us to abort it, but she insisted that she wanted to bear my child because she had seen a fatherly figure in me. So it starts from there, fatherhood starts from there.

Similarly, thirty-year-old Eric, a marketing officer who lived in Accra and had been married to his wife for two years, thought fatherhood began when a man began providing for his partner. He spoke about "fathering" a wife, in the sense of taking care of her:

> When I met her, everything that I feel a man should or a father should do for a wife, I did them. You support her and provide the basic needs for a wife. As you are a father, even though you do not have a child, you are somehow fathering the woman. So you have to do what she wants. Not everything though, but the things that you think are reasonable.

The above cases indicate the strong links among being a responsible provider, fatherhood, and masculine ideals. Performing the roles of a responsible father before initiating biological fatherhood contributes to shaping a solid masculine identity. As one participant stated, this separates men from fathers. Based on these views, adult masculinity and fatherhood shape each other through the same process: qualities expected of adult males are also expected of a father; however, masculinity is perceived to be incomplete until men "father their own blood," as narratives from the next section indicate.

Biological Fatherhood

According to the study participants in both Accra and Sakora, having biological children is decisive in reaching adult masculinity. This expectation was formulated most strongly by participants in Sakora, where young men commonly become fathers before they can provide for the woman and child. As a group of men unanimously communicated in a focus-group discussion in Sakora, "barima ni nea nu tuo apaye." (A man is one whose gun [penis]

has burst or fired.) In earlier days in Sakora, the bodies of men who had died without having biological children were castrated before the burial and were not given burial ceremonies like men who had had children. Although this practice has long since been discontinued, the underlying cultural ideals still resonate with young men. Peers and community members still sometimes stigmatize men who do not have biological children. According to some participants, having a child transforms boys into adult males and permits their participation in male activities in the community. Kojo said:

> I am young, but due to the fact that I have a wife and a child, I can be called a man. If men are called, I will join them, because I qualify.

Kwabena Yeboah had lived in Sakora for more than ten years. He had been married for seven years and was expecting his third child. He thought the community persuaded young people to have children:

> Well, as for this place, when you grow up and you do not have a child, people start talking about you. Most of the men get into marriage because of children and the pressure from people in the community.

Kweku was twenty-one and the youngest male participant in this study. Whereas all other fathers in Sakora who participated in this study were living with their partners and had children, Kweku was a young expectant father who did not live with his pregnant girlfriend. He is an example of young men who become fathers before reaching what is perceived to be responsible adulthood and do not have the ability to provide for others. He said:

> People will ask why the man doesn't have a child at his age, but they do not ask men who have children why they have the children, so it is something the community expects from men.

Some fathers in Accra expressed similar views. Martin was a thirty-eight-year-old man who managed his own mechanical shop in Accra and was expecting his first child. He said that caring for others does not give you the same respect as caring for your own child:

> People would think you are not a man or potent or something, so it is good to be a father. If you are alone without a child in the community, you will not be regarded and respected like someone who has a child. As soon as they know that you do not have a child and you don't look after anyone, you won't be respected. [. . .] Even if you take care of someone's child, they will still insult you because you do not have your own blood.

Having your own biological children, or your own blood, was also associated with sexual performance, as Eric mentioned:

> If you are a man, as they say, and you cannot fire, a whole lot of things come into people's minds. People will say "this man is not a man," but when you have a child, fine, then you are classified as a man.

Narratives of fathers in Accra suggest that infertility and impotency among men are stigmatized conditions and that men prove their sexual potency by having biological children, which may also be a sign of being a strong provider. Providing and caring for someone else's child, kin, and partner signifies good fathering abilities, but it generates more respect when a man cares for his own biological child.

The journey toward becoming a father, according to our participants, can be categorized into three key stages or levels: preparedness and marriage, ability to care for partners and kin, and biological fatherhood. At each of these stages, men perform tasks and play roles that enhance their masculinity. Men who cannot perform at all three levels risk having their masculinity questioned, as with men who cannot have biological children. The next section explores notions of a good father and what is expected of a man who has transitioned into "real" fatherhood and has his own children.

Being a Father

Similarly to becoming a father, *being* a father comes with expectations of breadwinning. This was a persistent and strong component of the narratives that participants shared in both Accra and Sakora. As heads of households, fathers are expected to provide, protect, and lead their partners and children; however, that is not always enough to be considered a good father. Our material suggests that men are increasingly expected to share housework, care for their children, and at times spend "quality time" with their partners and children.

A Good Father Is a Breadwinner

Participants in both Sakora and Accra emphasized that a good father should care for and provide food, shelter, school, and medical fees for his wife and children. The inability to do so could bring shame to his nuclear family, as indicated in the quote below by Musa:

> A good father is the one who takes good care of his wife and children. Since we are farmers here, we usually do not give daily money for upkeep, but we make sure that at least the money for meat or fish is given to the woman. A good father must be able to do this. When the woman is not feeling well,

> he should be able to give her money to go to the hospital. A good father should also pay the school fees of his children. Some men do not do that. Women who are married to such men are teased in the society.

This quotation signals that a man may not be able to provide sufficiently all the time and that this may lead to his wife's stigmatization. Some participants said that effective communication between couples could protect a man's inability to provide and avoid stigma. They maintained that the couple can agree that the woman becomes the main breadwinner without making it known to the children and extended family members. It was also mentioned that some men may hide their inability to provide because of fear that their authority and the respect they wield from their partners, children, and kin will diminish. This concern illustrates the frailty of masculinity and how a failure to provide may lead to the loss of status and bring shame to the family.

A Good Father Pursues Equality and Love

Fathers in this study emphasized equal partnership as an integral element in current conjugal unions and that paying the bride price does not mean owning the wife. Nanasei, for example, had been married for more than fifteen years in Sakora and was one of the elders of the community. He said that equality and the pursuit of peace are increasingly becoming an integral aspect of conjugal relations today:

> In the olden days, they considered bride price a form of transaction so that men would treat the women with disrespect. Now, things have changed. We are all equal. We live in peace and respect both parties in the family.

Kwakye has been married for more than ten years and has three children. He is one of the fathers in Sakora who openly performed duties described as feminine, such as fetching water from the pipe station by carrying a pan on his head instead of using a gallon. Also, he prepared dinner for the family and took his children to the clinic when they were unwell. He said:

> Getting married to a woman does not mean you have bought her from her family or she becomes your maidservant. You should serve each other. When the baby is crying while the woman is doing something, you should take the baby and play with him.

Although not as explicitly as Kwakye, other fathers also talked about supporting their wives with household chores and childcare as part of the current aim for equality in the home. Kwabena Yeboah said:

> A good father will not let the wife do everything at home with the excuse of being busy or going to work. A good father will support his wife at home and help with the house chores. Even though he works, he will not let the woman do everything at home.

Although men assisted their partners in domestic work and spoke about equality between the spouses, this was practiced mostly in the private sphere. In public, most men in Sakora reported that they disliked walking with their partners and openly showing love. They reported that men who openly showed signs of love were called weak and that people could even accuse women in such relationships of bewitching their husbands. Thus, men were often said to express love to their wives and support with housework and childcare when out of sight of others. For example, one participant shared that he usually carries firewood for his wife from the farm but does not bring it to town. He leaves it at the outskirts of town for his wife to carry home, so that community members do not see him. During community gatherings, we observed that men sat in front, while women sat at the back, where they merely listened and did not speak. These narratives of our study participants, and our observations, tell about the difference in gender ideals and practice in public and private life. It seems that emerging men's gender roles, such as support with household and care work, are likelier to be displayed only in private.

Participants in Accra did not bring up the stigmatization of showing love openly to their partners, but mentioned that men could be stigmatized for performing housework in an urban context; nevertheless, they claimed that this should not prevent men from performing housework. They asserted that performing household and care work is about love and understanding between partners, which should override stigma. This implies that a gender-related stigma of showing affection persists also in Accra, but seemingly not to the same extent as in Sakora. Compared to Accra, Sakora is small, a community where residents know each other. Hence, rumors about men's conduct will easily spread to family, friends, and neighbors. Although rumors will surely spread in Accra also, they may not travel the same distance as in Sakora.

Narratives of fathers in Accra (more than in Sakora), moreover, focused on faithfulness. Eddie was a twenty-eight-year-old man who cohabited with his partner in Accra. They were expecting their first child:

> As a good father, it is best to have all your children with one woman. You should not make your wife sad by cheating on her.

Maintaining multiple sexual partners and polygamy have customarily been identified as masculine definers in Ghana; however, participants from Accra said that they do not consider maintaining multiple wives or sexual partners,

because it may hurt their partners. Other participants in Accra talked about demonstrating emotional and physical involvement in the lives of their partners and children. Joseph said:

> You have to feel for the woman, consider her as your mother or your sister. Consider how you would treat them if she were them.

Martin added:

> If you don't love the mother [of the child], it means you don't love your child. You have to love and care for the mother before the child. You have to love both of them equally. It is not possible to love the child and not love your wife.

Eric added:

> Fatherhood now is becoming something like a family thing, because more men are supporting their wives. Like the way I come to the antenatal, the way I walk with her—we go to places during the weekends; we spend time together.

The use of the term *family thing* to describe fatherhood is indeed indicative of the nuclear family structure that has gradually replaced the extended family in Accra. Fathering in this sense is perceived to be more related to the immediate, nuclear, rather than to the extended, family. The description also refers to living separately from the extended family and making independent decisions on how to manage the home.

Participants in Sakora did not mention love, emotional care, or spending time with their wives and children as aspects of being a father, although they stressed mutual respect and equal partnerships. They also did not mention faithfulness or having children with only one woman, perhaps due to the widespread occurrence of polygamy in the Afram Plains. Sakora is a rural community, where providing material resources is likely to be valued more strongly than other aspects of fathering. Moreover, fathers in Sakora spent a lot of the daytime with their partners, and sometimes also with their children, working on the farm. Fathers in Accra were separated from their families for long hours during the week, and the separation seemed to call for allocating particular time for their partners and children.

Discussion

Our study found that fatherhood is central to adult masculinity and can be attained at three different stages. In the first stage, boys transition into adulthood through socioeconomic preparedness and marriage. In the second,

young men provide for partners and kin. Finally, men achieve adulthood through fatherhood by having and caring for their own biological children. The expectations of adult males described by study participants are consistent with Miescher's (2003) description of adult masculinity in precolonial Kwahu. From participants' narratives, adult masculinity appeared as the dominant masculine ideal, resonating with the concept of hegemonic masculinity in Connell's theory. As we have seen, biological fatherhood is also a central element of adult masculinity. In fact, as Miescher (2007) indicates, a childless man in Kwahu could not become a respected adult. Similarly, participants in this study who provide for kin and partners but do not have biological children may be stigmatized as impotent or infertile—which can in turn undermine other masculine gains, such as the ability to provide. For some participants in Sakora, having biological children, even if they cannot provide for them, is enough to attain adult manhood (see also Owusu and Bosiwah 2015).

Akosua Adomako Ampofo, Michael Okyerefo, and Michael Pervarah (2011) have argued that phallic competence is a marker that men can provide for someone. Similarly, our study participants in Accra also said that having their own biological offspring proves that they are real men because it shows their ability to provide. The concept of masculinity as the ability to provide is widespread in Ghana, as other recent studies have shown (Lambrecht 2016; Nukunya 2016; Nyarko 2014). Fathering biological children thus provides a vital site for engaging adult masculinity understood as hegemonic masculinity. Biological fatherhood is important for the continuity of the family lineage in Ghana, irrespective of ethnicity or system of inheritance (Adomako Ampofo, Okyerefo, and Pervarah 2011; Nukunya 2016).

The desire to father one's "own blood" forms part of a central status change for men, as they have contributed to the continuity of the family lineage in a manifest manner in both patrilineal and matrilineal societies. It has been argued that marital unions in Ghana are becoming stronger than lineage ties (Nukunya 2016; Oppong 1980, 2012). Men's responses about biological fatherhood in this study did not indicate differences according to ethnic or lineage affiliation. All participants' narratives show that it is important for men to have their own biological children and provide for their nuclear families.

In addition to having biological children and providing for them, our participants said it was acceptable for fathers to perform caregiving and housework. This acceptance was linked to notions of love and equality. In Accra, men emphasized love for their partners, while in Sakora, men emphasized the ideals of equal partnership in the conjugal union. Additionally, most spouses of fathers who participated in this study from Sakora and Accra were engaged in economic activities outside the home. The women's working situation is therefore likely to play a role in men's acceptance of male performance of caregiving and housework, as many studies have shown (Atobrah and Adomako Ampofo 2016; Boni 2002; Clark 1999; Ganle 2016; Kwansa 2012). Men's acceptance of caregiving and performance of

housework is indicative of involved fatherhood as described by G. R. Farstad and K. Stefansen (2015; see also Magaraggia 2012; McGill 2014).

Unlike in some studies, our participants argued that the payment of bride price is not a justification for subordinating women, and they expressed an interest in pursuing equality in conjugal unions (Adinkrah 2017; Coe 2012). Men also expressed an interest in pursuing peace, harmony, and companionate relationships with their partners. An example is their acceptance of performing roles previously defined as feminine in pursuit of love and conjugal happiness. Another significant indication of a move toward involved fatherhood in our study is the expectation that fathers will spend time with their nuclear families. These new expectations of fathers are indicative of emergent masculinities (Inhorn and Wentzell 2011).

Inhorn and Wentzell's (2011) notion of emergent masculinity indicates a social transformation of masculinity that is happening gradually, in a soft and often nonconflictual way. Emergent masculinities do not necessarily replace existing ones, but are gradually incorporated into patterns of everyday life. This is how adult masculinity seems to be expanding, according to our participants' narratives; however, incorporating new ideals is not completely without friction. Adopting elements of involved fatherhood could endanger masculinity, especially in Sakora, as it requires the (semi)public performance of feminine roles. Men talked about equality in conjugal relations, yet displayed hierarchical gender orders in public.

A recent study conducted among university students in Accra found that men who take paternity leave are stigmatized (Fernández-Cornejo et al. 2019); however, our study participants from Accra said they could perform household chores and care work publicly and seek permission for paternity leave. Indeed, participants from Accra had taken leave from work to participate in antenatal care, but the possibility of performing supposedly feminine tasks is linked to a context in which they are separated from their families and kin and so will not feel the disapproval of significant others (see also Overå 2007).

Elements of emergent masculinities were encountered in the narratives from both study settings. In becoming and being a father, participants in this study have not limited their perceived gender and fatherhood ideals to a singular pattern. In conjugal unions, many fathers found it acceptable to engage in practices that would promote companionship and maintain the quality of their relationship and families. In public, the same men, however, could be observed engaging in practices that are more consistent with hegemonic masculinity in Ghana to avoid stigma for themselves—but also, sometimes, for their wives.

The narratives of study participants suggest that adult masculinity is expanding to include involved fatherhood. As elements of involved fatherhood gradually enter young people's gendered expectations, hegemonic masculinities in the form of patriarchy, viewed as the rule of the husband and father (Wærness 2012), could be weakened. While some men feel they are free to expand adult masculinity by incorporating elements of involved

fatherhood, others feel they are constrained by stigma. Although involved fatherhood could spark some tensions in the community for men, emergent masculinities are nonthreatening and do not make a notion of adult masculinity based on having biological children and the ability to provide for them disappear.

NOTE

1. See also Atobrah and Adomako Ampofo 2016; Avotri and Walters 1999; Oppong 2004, 2012; Quinsumbing, Hallman, and Ruel 2007; Waterhouse, Hill, and Hinde 2017.

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RESEARCH

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"I came to escort someone": Men's experiences of antenatal care services in urban Ghana—a qualitative study

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Abstract

Background: Male involvement in maternal healthcare has been widely recognized as essential for positive health outcomes for expectant mothers and their unborn babies. However, few studies have explored men's experiences of maternal health services. The purpose of this paper is to explore men's involvement in antenatal care in urban Ghana and to discuss how men navigate their roles in a space that has been constructed as feminine. The study draws upon theories of space, place, and gender.

Methods: A qualitative exploratory study using semistructured interviews, focus group discussion, and observation was conducted in Accra, Ghana. Expectant fathers and health workers were interviewed, and observation was conducted at a selected public hospital in Accra.

Results: The findings suggest that the few men who attend antenatal care with their expecting partners become involved to a limited extent in the clinic's activities. Beyond a few who take an active role, most men stay on the outskirts of the hospital grounds and rarely participate in consultations with their partner and midwife. Men still view their presence as necessary to acquire knowledge and as sources of emotional, financial, and physical support for their partners. On the health workers' side, the study found no clear agenda for engaging men at the clinic, and nurses/midwives felt there was a lack of staff who could engage more directly with the men.

Conclusion: The study indicates that most expecting fathers feel too shy and uncomfortable to locate themselves in the female space that makes up antenatal care/maternity wards. Health workers do not feel they have the necessary resources to involve men fruitfully. Thus, men do not engage in the activity as hoped but rather remain on the outskirts of the maternity clinic. However, if men continue to negotiate their involvement at the clinic and become more assertive in their roles, the maternity clinic as a female space could, with time, be transformed into a space in which both expecting mothers and fathers can actively participate and be engaged to the benefit of all.

Plain Language Summary

This article discusses men's roles and involvement in health workers' activities when they accompany their pregnant partners to the maternity clinic. Health workers organize antenatal care services (ANCs) for expectant mothers

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to receive regular check-ups during pregnancy. Since pregnancy and childbirth are generally viewed as women's domains, men have not traditionally been expected to attend antenatal care with their partners. However, recent national and global agendas have recognized men's inclusion in maternal healthcare as central to improving mothers' and unborn babies' health. Men are being encouraged to play an active role in supporting their partners during pregnancy, and as part of this role, they are encouraged to attend antenatal care services. In the health facility where this study was conducted, we found that the few men who attended antenatal care most of the time stayed outside the maternity clinic under trees or in other empty spaces around the clinic. They opted to remain in the outside areas because they felt shy sitting among women who were a substantial majority at the clinic. We also found that health workers rarely involved men in ANC activities because of a lack of staff to engage men in separate sessions. Although the fathers attending antenatal care were disappointed that they were not engaged in activities, they still found it necessary to attend to give their partners emotional, physical, and financial support. Without the consideration of how ANC activities are structured and the appropriate resources for health workers, men's active participation in ANCs will remain minimal.

Keywords: Men's involvement, Antenatal care, Space and gender, Ghana

Background to the study

In sub-Saharan Africa, men have, to a large extent, been viewed as the leading decision-makers in the household responsible for the financial resources of the family [1–4]. Men's ideal roles as leaders and providers in the household have implications for women's access to quality healthcare during pregnancy and childbirth. When and where to seek healthcare and how much to spend on healthcare, as well as decisions about the number of children in a family largely depend on male partners [4–9]. Positive health outcomes for women and children have been associated with male involvement in both developed and developing countries [10–12]. Consequently, male involvement in maternal and infant healthcare has been encouraged to improve women's and children's health and promote gender equality in reproductive health responsibilities [13–16].

Research has shown that male involvement is significant in women's use of maternal health services [13, 17–19]. In addition to providing material resources to facilitate attendance, men can use their influence to demand respectful care and act as patient advocates [20–22]. However, a number of factors, such as the fear of having to be HIV tested, long waiting hours, the attitude of health workers toward men and the idea that pregnancy is a woman's responsibility, have been found to prevent men from visiting maternity clinics with their partners [7, 23–30]. Among the limited research conducted on the experiences of men who attend antenatal care (ANC), a study from Rwanda indicates that even when men accompanied their partners for antenatal services, midwives prevented them from participating in private consultations to protect their professional domains and maintain the maternity clinic as a space for women [31]. A study from Malawi on men's labor and birth experiences found that men experienced increased knowledge but felt fearful, embarrassed, and helpless when witnessing their partners in labor [32].

Studies on male involvement in reproductive health in Ghana have primarily focused on family planning [5, 9, 33, 34]. Other research in the field has discussed factors that prevent men from attending maternal healthcare clinics and has identified expected gender norms, lack of time and low formal educational status as the causes of low male attendance [2, 4, 8, 35–42]. Hence, the experiences of men who try to participate in maternity care services have remained undocumented in the Ghanaian research-based literature. This article focuses on men who attend antenatal care (ANC) with their partners, and it attempts to enhance the knowledge about and understanding of expectant fathers' experiences of the service. Given the premise that men's involvement in ANC strengthens reproductive health, knowledge about their experiences at clinics is important to indicate what may be productive or achievable. This study presents the varying forms of expectant fathers' involvement in ANC and how the organization of the activities and space at the maternity clinic shape what fathers do while there. We draw upon theories of space, place and gender to augment the understanding of the material [43].

Conceptual framework

Following Doreen Massey [43], we understand space to comprise social relations, while a place is where these relations are performed, constructed, contested and renewed. The formation and identity of a place, its social structure, political character and local culture are all products of interactions [[43], p. 120]. Both spaces and places are therefore formulated in terms of social practices. Gender is influential in defining the kind of relations that are played out in particular places and in shaping the way that men and women relate in a place.

Massey [43] noted that the dominant image of a place and space will often be contested and subject to gradual transformation.

The place under discussion in this context is a maternity clinic where expectant mothers gather as a group led by health workers. The maternity clinic can be described as an example of a "third place". Third place has been defined as "physical locations outside the home (first place), or workplace (second place) that facilitate social interaction, community building and social support" [[44], p. 1] [45]. The maternity clinic is a physical location where women and their caregivers share reproductive health information and a place where women form social relationships with other expectant mothers. In this way, the clinic supports and sustains women's social life during pregnancy.

The continuous interaction of pregnant women and their caregivers at the maternity clinic, discussing reproductive health matters, has constructed the maternity clinic as a female space where masculine presence and domination have been rather peripheral. However, when men visit the maternity clinic, it is expected that they share the same space with their partners, a space where their defined hegemonic roles [46] as heads of the household are of little or no significance. In this regard, we seek to discuss how the maternity clinic as a physical place and socially constructed space is being potentially reshaped to include men and how men negotiate their authority and masculinity within this space.

Methods

Study design

This article forms part of a broader study that the authors conducted between June 2017 and May 2019 to explore the nexus of male involvement in maternal healthcare and gender relations in Ghana. The study used an exploratory qualitative research approach to present detailed descriptions of people's own understanding of events and experiences [47]. Semistructured interviews, focus group discussions (FGDs) and observations were used to gather in-depth knowledge about how activities are organized at the maternity clinic of a key government hospital in Accra.

Study setting

The study was conducted in Accra, Ghana's capital. All participants were recruited through one of the fully government-operated hospitals in the Accra metropolis. The particular hospital was selected as the main facility in the study, as it is a key government hospital in Accra and provides services through National Health Insurance. Moreover, a government facility was selected because its clients represent people of different social statuses in Ghana, unlike private facilities that are likely to have wealthier clients.

Participants

Participants contributing to the data illustrated in this article are expectant fathers, midwives and community health nurses.[1] Purposive sampling was used to recruit men and health workers. The recruitment proceeded as follows: the first author (GAA) started out by observing expectant mothers and fathers as they came to the maternity clinic. She also joined the antenatal education sessions and took note of the men present, their level of involvement in activities, their body language, and their interaction with service providers and other men and women. She then approached these men after the educational sessions had ended and informed them about the project individually. Observations and recruitment continued over a seven-month period at the maternity clinic. The inclusion criteria for the men were first-time expectant fathers who were regular attendees at ANC. Because expectant mothers are required to attend at least four antenatal visits, one inclusion criterion of expectant fathers was that they had attended ANC at least twice before the interview. All men were recruited at the hospital and followed up on with phone calls to schedule interviews. Follow-ups presented an opportunity for the researcher to establish rapport with the participants and gather more background information before the actual interview took place. Not all men contacted were able to participate in the interviews; some did not meet the inclusion criteria, while others could not find time to participate. Ten men were interviewed. All except one were first-time expectant fathers. One father had a child from a previous relationship, but this was revealed only after the interview.

Topic guides

GAA conducted all interviews and the focus group discussion using three different open-ended topic guides. The topic guide for the qualitative interviews with the fathers focused on four main topics: fatherhood and masculine norms within the Ghanaian social context; fathers' roles during pregnancy and childbirth; the role of the extended family during pregnancy and childbirth; and the experiences of fathers at service points, including the maternity clinic. The second topic guide for midwives focused on perceptions about fatherhood norms, benefits of male involvement in service delivery,

[1] As part of the broader study, interviews were also conducted with expectant mothers in Accra, and health workers and expectant parents in rural areas, but these interviews do not form part of the data used for this article.

ways of engaging men at the clinic, and the potential challenges of male involvement at the clinic. The third topic guide used in a focus group discussion with community health nurses (CHNs) focused on perceptions about fatherhood norms, benefits of male involvement as observed in the community and at the health facility, ways of engaging men in maternal health at the clinic as well as in the community, and the potential challenges of securing male engagement at the community level and at the clinic. Because the instruments were open-ended, GAA could adjust the questioning to suit the individual participants' situation. She also engaged in a continuous review and rephrasing of the questions to ensure that they were clear and comprehensible to the research participants.

Data analysis

The data were analyzed using Braun & Clarke's [48] approach to thematic analysis. Data analysis began with the writing of an analytic memo, which was updated periodically during fieldwork. Key concepts that participants mentioned were recorded in an analytic memo and later used to generate codes. Soon after gathering the data, all the tape-recorded audio was transcribed and anonymized to protect the identity of the study participants. Upon transcription, a few interviews were printed out and coded on paper to develop a coding manual. All transcripts were later transferred into QSR NVivo software, where more codes were generated. Themes were generated from the codes, and some themes were merged with other themes upon consultation with the research team. Themes were continuously refined by the coauthors.

Ethics

The study is guided by the protocols of the Norwegian Institute for Data Protection (53,570/3/ASF). Ethical approval was granted by the University of Ghana, College of Health Sciences (CHS-Et/M.6–P1.12/2017–2018). Permission was also sought from the administration and the maternity clinic of the hospital before the study began. Written or oral informed consent was obtained from all participants after thoroughly explaining the purpose of the study [49]. Moreover, interviews and discussions were recorded only upon the acceptance of the participants. The participants were informed that they could withdraw their consent at any point during the session without any consequences and that information gathered from the study would remain anonymous. All participants were given pseudonyms to enhance anonymity.

Results

This section presents a description of the maternity clinic, how ANC activities were organized, and where men were located during the clinic's proceedings. It will then continue with a discussion of the varying forms of male involvement found in the study, including men's own agendas at the clinic. It ends with a presentation of health workers' engagement of men at the clinic.

The maternity clinic and male partners

The maternity clinic was managed by a midwife and offers three fairly distinct services: antenatal care, labor and delivery care, and postnatal care. The *antenatal care* (ANC) division had one gynecologist and approximately four midwives per work shift. The clinic operates between 8 am and 5 pm from Monday to Friday. Mothers began to arrive as early as 6 am to form a queue, sometimes coming in the company of other mothers or partners. By 8 am, when sessions started, the seats in the waiting area where ANC takes place were usually fully occupied by expectant mothers. The sessions commenced with a midwife leading the expectant mothers in the waiting area in a Christian worship session lasting approximately ten minutes. She then led the group in a short exercise session before giving an educational talk on topics such as nutrition, birth preparedness, and signs of labor, among others. More mothers arrived as the educational session proceeded. On average, approximately 200 women attended ANC at the hospital per day.

During the session, mothers talked among themselves and with health workers, asked questions, and shared jokes. When the educational session ended, individual mothers were called upon, and their folders were sorted according to their assigned midwives. At this point, women waited for a one-on-one consultation with their assigned midwives in a separate room. This is a crucial service provided during ANC. Although the waiting area was largely congested during the educational session, the space began to open up as the educational sessions closed and women continuously moved in and out of the clinic. It was common to find expectant mothers moving around in pairs or more to the canteen, washroom, and laboratory. Women who attended the clinic with their partners walked around with them.

Men who accompanied their partners to the clinic were encountered mostly at three different locations. Some sat among the expectant mothers in the waiting area during the educational sessions. From observation, we found only two to three men sitting among the more than 100 women. Others stayed in an open space outside the maternity clinic, while others again were seen under trees on the broader compound of the hospital. Although men may not be present in the waiting area,

they were still sometimes called by their partners to join them for the one-on-one consultation. Statistics from the hospital show that between 2016 and 2019, male attendance at the maternity clinic had a ratio of approximately ten mothers to one father. These numbers include men who came for antenatal, labor and delivery care and postnatal care. Labor and delivery care have the most sizeable male attendants, according to health workers. Thus, very few men attended ANC sessions with their partners. From the few men who came for ANC, we found different ways and levels of involvement.

Varying involvement of men in antenatal care

The first question that we asked men after greeting them at the maternity clinic was, "What brought you here today?" Most men responded by saying, "I came to escort someone". This response was also clear in the ways that men and women occupied space at the hospital. While women usually gathered in the waiting area, most men were, in contrast, found waiting under trees and in isolated spaces behind the clinic. Expectant fathers who remained outside during the general session said that they were uncomfortable inside the maternity clinic. One man, Ibrahim, for example, said that he was surprised to see so few men when he attended the clinic with his wife for the first time, and this made him feel uncomfortable. Another expectant father specifically mentioned that he was uncomfortable sitting among the women:

> *I would not like to be among the ladies. That place is only meant for the women. So if I come with someone, I would not like to sit among the ladies (Elorm, 30 years old, Artist).*

Other expectant fathers decided to make themselves invisible at the clinic, saying it was because they felt shy. When we interviewed one man, Derrick, for the first time, his wife was eight months pregnant. He had attended the ANC since they received a positive pregnancy test. However, sometimes the midwives did not even see him because he was mostly hanging around under the trees surrounding the facility. He did not participate in either the educational or the consultation sessions because he did not see other men doing so. He nonetheless concluded by saying that if he is invited, he will join the educational session. He explained:

> *I feel shy. Well, I do not go into the room with her unless I am invited. The only time I went inside was when I was called to donate blood. I have not been there since then. If it is allowed, I will go (Derrick, 32 years old, Truck Driver).*

Some men revealed that they were only shy during the first visit and later became more comfortable sitting among the expectant mothers in the waiting area:

> *When you come for the first time, you would be shy because you would meet many women, and the reaction from their faces would be like: "Ah, is your wife the only pregnant woman?" Well, fortunately, I do not take notice of such things because I know my purpose there. So I just sit quietly and mind my business (Joseph, 32 years old, Sales Manager).*

Although the seats in the waiting area were mostly fully occupied by expectant mothers, none of the men interviewed mentioned a lack of seating space as the reason they waited outside. Instead, as we have shown above, they related their staying away from the waiting area to experiencing shyness and discomfort. Some expectant fathers were unhappy with a limited level of involvement at the clinic and felt that activities should be tailored to include them, especially in the individual consultations:

> *The only time you will see the nurses is when they come to mention the names of those whose cards they have. So when they are calling the names, and you are also following, you know the nurses are rude at times. They ask where you are going and all sorts of questions. In addition, even seeing some of the men around, even though most men do not come, at least they should come and ask what we came to do or who we came with and all that. They just move back to the rooms after mentioning the (women's) names (Eric, 30 years old, Sales Executive).*

Like Eric, some of these men seemed not to be aware that men were allowed to participate in the consultations. Derrick also said he would participate if it were allowed. Ibrahim similarly said:

> *We came together, we even went down there, but I am currently sitting here because she is going for a scan, and she is the only one expected to be present there. After the scan, the next is the lab and a whole lot before seeing the midwife. That is why I am waiting for her here (Ibrahim, 32 years old, Trader).*

When asked whether he would join his wife in the consultation with the midwife, he answered, "*If I am permitted, why not?*".

Interaction at the clinic was, for most men, limited to interacting with their partners. There was hardly any communication between the men themselves or between men and women. Most men played on their mobile phones and tablets in their idleness. They explained that

it was better to focus on their purpose at the clinic rather than chatting with other men.

The men who kept a distance and did not involve themselves in activities at the clinic were a substantial majority among our study participants. However, there were also a few who were more assertive and actively participated in the consultation with their partners, as shown below:

> *As for the consulting room, I always make sure I am there with her because I want to see if everything is in place. So if there is any lab test, I would like to know its result and what to do about it. We went there together yesterday when the time was due for the test they conducted. That was when she (midwife) told us what to buy for the child and other things needed for the pregnancy (Eddie, 28 years old, Self-employed).*

Eddie usually joined his partner for the educational session and would after that drop out and wait outside until it was time for her consultation with her assigned midwife when he would be called to join in. Charles was another man who said that he regularly participated in the consultation with the midwife. When observed at the clinic, Charles appeared to be in control and aware of his rights and privileges, leading his wife through the various proceedings, carrying her folder and handbag while she followed behind. Men such as Derrick became more involved in activities toward the end of pregnancy. His wife developed complications in the third trimester, which required that she attended frequent check-ups. Upon the request of his wife's assigned midwife, Derrick joined the consultations when his wife's due date was drawing closer.

Men's agenda at the maternity clinic

Irrespective of the varying forms of involvement at the clinic, expectant fathers seemed to have their agenda for attending ANC with their partners. Observations showed that most men at the clinic made payments on behalf of their partners, bought them food, and carried their handbags and folders. One expectant father, Eric, for example, was observed at the clinic sitting in an empty space, holding his partner's handbag and folder. Although Eric was disappointed that health workers did not involve men in the ANC activities, he found a way to make himself useful. Our study participants also shared that they performed some roles in the form of seeking knowledge and providing emotional and physical support for their partners at the clinic.

> *I always want to come here to know more about pregnancy, so I do not take anything for granted. Sometimes, the woman may complain of a headache, and you would not know what that means, but when you come here, and they teach, you would know how to treat such things. It helps me to take good care of her. Sometimes she forgets the things they teach there as well, so when I go there, I take notes like a student so that I do not forget the lessons (Joseph, 32 years old, Sales Manager).*

The quote above indicates two motivational elements of men attending ANC: to acquire knowledge and remind their partners of information relayed at the clinic. Some expectant fathers understood antenatal visits as an extension of their role as the head and protector of their family:

> *This is her first time she has been pregnant, and her family members are not here. So I am supposed to support and help her out during this time. I have some questions to ask the midwife. She alone will not be able to ask all those questions, you know. How will she do all that because she is a young girl and does not know anything about pregnancy (Elorm, 32 years old, Artist).*

Men also claimed that spousal love and affection were a key motivation for their involvement in ANC with their partners. When asked why he continued to attend ANC with his partner, Charles answered, "The woman, she is good". Similarly, men emphasized that attending ANC was an expression of love for their partners. They explained that experiencing the process of pregnancy with their partners will promote respect for women, as indicated in the two quotes below:

> *I am happy that I came here with her because she knows that I support her. Just staying away from work for a day for her will not affect anything. Just knowing that I support her in the pregnancy gives me joy as well (Martin, 38 years old, Mechanic).*
>
> *It is good for every man to go through that process to have some respect for every woman they see. Some men do not respect women. All they care about is, hey, after all, she is just my girlfriend. They do not see them as their fellow human beings and treat them as such. I believe after they go through this experience, their respect and care for women would increase. So I think when you are always there with her throughout the process, there would be a change of mindset on how to treat women. It has truly changed my mind and mentality about women (Joseph, 32 years old, Sales Manager).*

Health workers engagement of men at ANC

In general, health workers seemed happy to see men at the clinic, although they had divergent opinions on

including men in the procedures. Apart from giving preferential treatment to women whose partners attended ANC, health workers had no clear agenda about facilitating male involvement in maternity services. Irrespective of what midwives viewed as the appropriate way to involve men in ANC, their primary concern was how male attendance demanded an increase in their already substantial workload. They held that it would be more convenient for health workers if ANC focused mainly or only on women.

Jumping the queue

Health workers mentioned that there is a recommendation to motivate men who attend ANC by allowing their partners to move more quickly up the line.[2] This principle is justified by the idea that men have to go to work as providers for their families, and therefore, their partners should be allowed to move more quickly up the queue so the men can go back to work. All health workers who participated in this study mentioned this incentive, summarized in the excerpt below:

> *When you come with your wife, we give you priority. We see you first. Because among the lot, approximately 200, 300, we have about five men. We treat you as a special guest for that day. That is what we have been doing. Even when I am walking around, and I see a man sitting, I ask the wife, which room do you go to? Then, I tell the midwife in that consulting room, do not forget there is a man there. See that person first (Naana, Midwife).*

However, this incentive and practice were not something we came across in the interviews with the men or in the observation at the clinic. Only one of our study participants, Charles, said that he "helped his wife to jump the queue". During the follow-up interview after birth, while Charles and his wife were expecting their second child, he still attended ANC to help his wife move more quickly up the line. Interviews and observations showed that very few men at the clinic knew of the incentive to give queue privileges to women who were joined by their partners to ANC. One reason for this might be that health workers in practice seemed to keep silent about this privilege and incentive. Naana, one midwife, explained that expectant mothers waiting for ANC regularly engaged in quarrels about issues relating to the queue and about people they suspected of cheating. Consequently, health workers gave this preferential treatment silently, and only men and women who were already aware of the privilege were able to take advantage of it.

Challenges of male involvement

Health workers shared different views on how men should be involved in the activities at the clinic and the challenges involved. Community health nurses talked about inadequate physical space for men at the clinic, while midwives talked about whether men's inclusion should be prioritized:

> *The women at antenatal care are usually very plenty. Sometimes they (men) enter there, and they see plenty of women there, and they will go back. We do not even have space (physical) for the men. Therefore, we are not making it comfortable for men to involve themselves (CHN, FGD).*

CHN's views on sitting/waiting space at ANC seemed to support men's concern that sitting among women was uncomfortable. Naana, as shown above, argued that men who accompanied their partners should be treated as unique and served quickly. Nevertheless, she believed that men's presence should not be a priority unless the condition of a pregnant woman demanded her partner's participation in ANC services. She gave the following example:

> *If your husband is not coming to postnatal with you or the antenatal, we are not bothered. We are not bothered. We only need the woman if everything is fine, yeah. Unless she comes and there is a problem. Then, we will call the man (Naana, Midwife).*

Rebecca, another midwife, said that men participating in the consultation would increase their workload. Therefore, she had suggested to the hospital that the morning sessions should be communicated through videos, which would include videos on what men can do to support their partners. Additionally, she emphasized that a separate men's group would be better than men participating in the private consultation. Nonetheless, this should happen only if and when specific health workers could be assigned to male attendees.

Agnes, another midwife, held a slightly different position and argued that men should participate in the consultations because it would make their work much more manageable:

> *As I said before it (male inclusion) is something very good and makes the work simple for us. When you tell them what to do and what not to do, the men*

[2] Health workers spoke about this incentive in the form of a policy that is implemented in all government health facilities in Ghana. However, we found no documentation to show that the Ghana Health Services has a policy that permits giving preferential treatment to women who attend the ANC with their partners. Another study by Ganle et al. 2016. "If I go with him, I cannot talk with other women," also mentioned a health facility giving preferential treatment but not as part of a health sector policy.

remind them (expectant mothers) at home to comply with the instructions. They (men) are always there to check their wives for us (Agnes, Midwife).

Agnes' claim here reiterates that health workers support the men's agenda for attending ANC to acquire knowledge and remind their partners at home of instructions received during the consultation. Unlike Rebecca, Agnes claimed that men's participation in consultations would neither prolong nor increase the workload. However, separation of the women and men would require additional caregivers and time, which the hospital may not have the capacity to provide. She concluded by saying that it would be possible to organize a separate information session for expectant fathers only when they start coming to the clinic in more significant numbers.

Discussion

As stated at the onset of the paper, global health research has demonstrated that active male participation in maternal healthcare services improves women's health outcomes and promotes gender equality in reproductive health [14, 15, 50]. Some literature from sub-Saharan Africa indicates that male partners attending ANC facilitate quality care for women by demanding respectful care and acting as patient advocates at health facilities [20–22]. Nevertheless, male experiences of ANC services have not received much research-based attention. Our study found that only a minority of pregnant women's partners came to the ANC, and those who did were actively engaged in the activities at the clinic only to a limited extent. While a few men did take an active part even in the individual consultation between their partners and the midwives, asked questions and helped to remember instructions, most men attending this particular ANC seemed to maintain a relatively distanced role.

In an attempt to gain in-depth knowledge and understanding of why men seemed to maintain a distanced role at the maternity clinic, we analyzed the data using the framework of space, place and gender [43]. This framework can elevate our understanding of how a physical place, such as the maternity clinic, can become a site of gender display and explain why men seemed to be marginalized. The identity of the maternity clinic is a product of the activities that have been produced and relations that have been constructed in the location over time [43]. As a physical location where women and health workers (also mainly women) interact and share knowledge on pregnancy and childbirth issues, the place has come to exist as a gendered "female" space.

The clinic also acts as an essential "third place" for expectant mothers. As a physical place located outside the home and the workplace, it promotes social interaction, networking, and support during pregnancy [[44], p. 1]. Antenatal care visits provide physical healthcare and support and sustain women's social life during pregnancy in the form of sharing information and creating long-standing social relationships and networks, including mother-to-mother support after childbirth. Women may be reluctant to include men to protect the relationships that they forge at ANC and preserve female autonomy over pregnancy and childbirth, as indicated in Ghanaian studies [2, 39].

Furthermore, maternity clinics function as safe spaces where mothers have reportedly preferred to discuss contraceptive use and other matters in their relationships with their peers and health workers without involving their partners, sometimes for fear of intimate partner violence [[2], p. 200]. Spousal violence during pregnancy is quite common, with "prevalence rates of 28–40% for physical, 3–27% for sexual and 25–49% for emotionally intimate partner violence" among pregnant mothers in Africa according to a WHO report [[51] p. 1]. Women who experience violence during pregnancy may be unwilling to attend ANC with their partners. For intentional and unintentional reasons, men have been marginalized in the maternity clinic's operation and interactions.

Our study suggests that men felt out of place at the maternity clinic. Indeed, at times, they remained almost invisible and physically distanced outside the maternity clinic. An indication of men's loss of confidence at the maternity clinic is related to their remarks about shyness that triggered their decision to remain hidden or to stay away from the waiting area even when they accompanied their partners. Men conveyed that they were uneasy as a minority in a predominantly female group, a finding that has also been reported in other studies [36]. Hence, they felt more relaxed when they withdrew to a space away from where large numbers of women would often be gathered, either to the outside of the maternity clinic building or to inside areas where the individual consultations took place, where only the man's wife and the nurse would be present in addition to himself.

Men's experience of discomfort at the clinic can also be related to their potential loss of autonomy in a space where they feel socially and spatially marginalized. As we have seen, the clinic is organized in a manner where the focus of the health workers, primarily women, is almost solely on the pregnant women. Thus, men, who in a home setting act as heads of the household, find themselves in a space occupied mainly by women. They feel uninvited to participate and have little to contribute to ongoing activities. In some cases, expectant fathers hoped to participate in the private consultation to ask questions that they maintained their partners would not properly ask themselves and to remind their partners of important health

instructions. Health workers acknowledged that men who participate in private consultations asked questions relating to their partners' health. Participating in the private consultation demonstrates men's efforts to share and contribute to their partners' maternal health while simultaneously presenting them with the opportunity to feel slightly more in control and reaffirm their masculinity.

Health workers acknowledged that they have some structural constraints that reduce their ability to involve men in ANC activities. Inadequate physical space and staff to organize separate sessions for expectant fathers are a real challenge, as illustrated in our study. This challenge has been documented in other Ghanaian studies, and maternity care services have been criticized as not designed to include men [8]. As part of the Ghana Ministry of Health's gender policy, health workers are encouraged to engage men to harness their support for appropriate decisions regarding women's reproductive health [52]. The policy also indicates that health workers should be supported with gender-sensitive training in preservice and in-service education to deliver gender-responsive health services [[52], p. 27]. Although undocumented, health workers claimed that there is a recommendation of giving preferential treatment to women who attend maternal health services accompanied by their partners to motivate men. The reasoning behind this incentive has been that men are breadwinners and therefore need to leave the maternity clinic quickly to go to work.

As articulated by some studies, a significant problem with this incentive is that women find the principle unfair to those who come to the clinic unaccompanied [2, 53]. Health workers in our study have also mentioned that they remain largely silent about giving preferential treatment to women who are accompanied by their partners to avoid conflict among expectant mothers in the waiting area. Moreover, this incentive may give the impression that the male figure is more important than the female figure at the maternity clinic and may reinforce gender discrimination. If such a recommendation were effectively implemented, it could encourage men to attend the clinics. However, in the long run, it could function against the promotion of gender equality in reproductive healthcare.

Despite the global and national emphasis on male involvement in maternal healthcare services [52, 54], men in this study assumed a minimal participatory role in ANC visits. They often remained outside the maternity buildings or even in more distant hospital quarters and primarily accompanied their partners to and from the hospital. A few became disappointed when they found that they were not expected or even allowed to take a more active and engaged role at the clinic. In this study, men's disappointment about the lack of facilitation to participate in consultations is similar to the findings from a Rwandan study where men were also reported to be disappointed that they were not involved beyond attending ANC [31]. Nonetheless, our study's findings indicate that attendance at the ANC implies a journey where men seemed to gradually become more involved; they become more accustomed to the setting and activities, and in the process, they become less wary of their own presence in a female space.

As Massey [43] has argued, the identity of places and spaces are subject to contestation and change over time. In this line of thinking, could the maternity clinic as a gendered space be transformed to accommodate a male presence with more active participation and inclusion of men? As we have shown, men's participation is limited and involves engaging with health workers only to a limited extent. Men felt anxious, invisible or out of place in the maternity clinic. However, we have also seen that male attendees strived to make themselves useful in a way that was compatible with their positions as heads of the household. Typical examples of such involvement found among study participants included blood donation, making payments, buying medication, and carrying their partner's bags and folders. Men also talked about reminding their partners of important health messages and instructions from the clinic. Moreover, our data indicated that men were motivated by love for their partners to become involved in ANC.

In summary, our findings suggest that men have actively initiated their participation in ANC more than health facilities and health workers. The examples of male involvement in ANC presented here substantiate the assertion that men taking joint responsibility for women's workload during pregnancy fosters a less stressful prenatal experience for expectant mothers [55]. Our research material also emphasizes the claim that men become exposed to new ways of relating to their partners through their involvement in pregnancy-related care, which could promote new fatherhood norms [55]. Perhaps with a strategic focus on the clinic's spatial setup and including men in the general sessions and private consultations, the maternity clinic could, with time, be transformed into less of a gendered space, i.e., a space that will accommodate both female and male identities.

Conclusion

This study has focused on understanding men's experience of ANC services using the conceptual framework of space, place and gender. The findings suggest that there are differing levels of male involvement in maternal healthcare services and that active participation of men is influenced by socially expected gender norms

and health facilities' structural factors. Although men seemed to have their own agenda for attending ANC, they felt uncomfortable in a space that was predominantly occupied by women, and they felt marginalized in the services provided by health workers.

ANC is organized for expectant mothers, and this core purpose should not be neglected out of an eagerness to include male partners. Concurrently, the importance of the presence of men who accompany their partners to ANC for various reasons cannot be overlooked. Active male participation in ANC offers an opportunity for the mobilization of men to reflect on and nurture new fatherhood norms and new ways of relating with their partners. Therefore, more research on men's experiences in ANC services at other government hospitals in Ghana will facilitate gathering the best evidence for appropriate ways to organize and stimulate gender-transformative norms.

An examination of the capacity-building needs of health facilities involving men in pregnancy and childbirth-related care would be beneficial. Considering the often-limited physical space and the limitation of health workers to engage men in separate quarters at ANC, health facilities should, at the discretion of health workers, assess what is possible within their capacity and resources to accommodate male attendees. Audio-visual materials for broadcasting male activities and responsibilities during pregnancy in maternity clinics' waiting areas may be further explored. Furthermore, gender-sensitive education in the preservice and in-service training of health workers could be enhanced.

Following the global surge in promoting male involvement in reproductive healthcare to improve women's and children's health and advance gender equality in reproduction, it is important to investigate and address the physical and social formation of maternity clinics. Without appropriate spatial arrangements and resources for health facilities and health workers, men attending ANC will not feel adequately involved, as highlighted in this qualitative study.

Abbreviations

ANC: Antenatal care; CHN: Community Health Nurse; FGD: Focus group discussion.

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Authors' contributions

GAA and HH conceived and planned the study and GAA gathered the data. GAA, HH and AB conducted the analysis and put together the manuscript. AK collaborated on reviewing and finalizing the manuscript. All authors read and approved the final manuscript.

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Field research for this project was funded by the Meltzer Foundation, a research fund attached to the University of Bergen. However, they did not play any role in designing, collecting data, analyzing, interpreting, and writing the manuscript.

Availability of data and materials

The datasets used and/or analyzed during this study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

The study is guided by the protocols of the Norwegian Institute for Data Protection (53570/3/ASF). In Ghana ethical approval was granted by the University of Ghana, College of Health Sciences (CHS-Et/M.6–P1.12/2017–2018). Permission was also sought from the administration of the selected Hospital and the maternity clinic of the hospital before the study began. Written or oral informed consent were obtained from all participants after thoroughly explaining the purpose of the study. Moreover, the participants were asked for the discussion and interviews to be recorded. They were informed that information gathered from the study will remain anonymous. All participants were given pseudonyms to enhance anonymity. The participants were informed that they could withdraw their consent at any point during the session without any consequences.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no conflicting interest.

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Publisher's Note

ARTICLE III

Title: 'I do not want her to be doing anything stressful': Men's involvement in domestic work during pregnancy in Ghana.

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Abstract

Drawing on qualitative research from rural and urban areas, this article contributes to evolving social research in Ghana on possible changes in the gendered distribution of domestic labour. Formulated within debates on 'doing gender' and 'undoing gender', this study examines the extent to which acts of gender transgression may potentially occur during peak reproductive periods in the lives of Ghanaian couples. The findings of the study indicate that the participants reiterated normative gendered definitions of men as primary providers and women as primary domestic caretakers. Nonetheless, it was noted that during their partner's pregnancy, men in both urban and rural areas were willing to modify their daily schedule to incorporate more housework. Simultaneously, male involvement in all or most of the household chores was perceived as potentially dangerous to the gendered balance of labour in the family and could, according to the participants, stimulate laziness among female partners. Despite the apparent resistance to male performance of domestic chores, the article argues that men's willingness to do housework during their partner's pregnancy may be an early indicator of slow but steady transformations in gender relations in Ghana.

Keywords: Household gender relations, doing gender, undoing gender, male involvement, domestic work, Ghana.

Introduction

In his article 'A Radical Agenda for Men's Caregiving,' Gary Barker (2014: 87) argues that alongside the global efforts to elevate the value of women's work in domestic and reproductive arenas, it is equally essential to encourage men to participate in domestic and care work. In many contexts, domestic work and caring for children are still primarily defined as feminine tasks, irrespective of women's increased participation in paid labour (Ayentimi et al., 2020; Barker, 2014; Bosak et al., 2017; Doyle et al., 2014; Kato-Wallace et al., 2014; Morrell and Jewkes, 2011). Women's responsibility for the bulk of house and care work keeps their wages proportionately lower than the wages of men; furthermore, it impedes women's career development goals and promulgates unbalanced gendered power relations in social and political spheres (Barker, 2014: 87; Matteazzi and Scherer, 2020). Subsequently, Barker (2014) suggests a global plan that envisages men and boys doing 50% of the domestic and care-related work. This suggestion is based on the postulation that an increase in men's uptake of unpaid domestic work may transform dominant gendered responsibilities in a manner that will translate into improved global gender justice (Barker et al., 2010; Barker, 2014; Dover, 2014; Doyle et al., 2014; EU, 2013; Morrell and Jewkes, 2011; UN, 2011).

Advocating for an increase in men's uptake of domestic work implies the need for more local studies that investigate the perceptions, experiences, and practices of men and women surrounding men's work in the household. Studies conducted in the last ten years have discovered an evolving tendency towards a more equal distribution of domestic chores among intimate partners in Sub-Saharan Africa (Comrie-Thomson et al., 2019; Kwansa, 2012; Morrell and Jewkes, 2011; Mkandawire and Hendriks, 2019). Our article attempts to add evidence to the claim of a possible shift in household gender relations, focusing on men's participation in domestic labour during the period when the couple is expecting a child, i.e., when the woman is pregnant.

In the Ghanaian context, according to data from 2014, women reportedly spent twice as much time on unpaid domestic services than men (GSS, 2014b: 153). This trend in the distribution of domestic work has been largely linked to gendered expectations in the local culture. The dominant household arrangement expects that men take a leadership role in their families and provide the family's income, while women perform domestic and care duties (Adomako Ampofo, 2001; Adomako Ampofo and Boateng, 2007; Awinpoka Akurugu, 2019; Bosak et al., 2017; Dako-Gyeke and Owusu, 2013; Frost and Dodoo, 2010; Lambrecht, 2016; Nukunya, 2016; Sikweyiya et al., 2020). This pattern of household labour division is reinforced through proverbs and daily social discourses that hold people accountable when they engage in gendered behaviours that are perceived as inappropriate (Adomako Ampofo, 2001; Adomako Ampofo and Boateng, 2007; Awinpoka Akurugu, 2019; Dako-Gyeke and Owusu, 2013). For example, the proverb, 'the hen also knows that it is dawn, but it allows the cock to announce it' (Adomako Ampofo, 2001: 199), illustrates men's leadership roles and the expectation of women not to interfere with this role.

Simultaneously, Ghanaian women have consistently been acknowledged for their engagement in economic activities outside the home to boost household material resources (Atobrah and Ampofo, 2016; Clark, 1994; Oppong, 1980; Salifu, 2020). Women's involvement in economic activities outside the home became even more notable following the implementation of the structural adjustment programmes (SAPs) of the 1980s (Avotri and Walters, 1999; Waterhouse et al., 2017). During the same period, men ventured into economic activities, such as petty trading, that were hitherto viewed as 'feminine' (Overå, 2007). Nonetheless, the expectations and ideals encompassing the domestic arenas have remained associated with femaleness. This expectation is entrenched in Ghanaian society to the extent that women may experience intimate partner violence for not doing housework (Dako-Gyeke et al., 2019).

Although the 'male breadwinner' and 'female domestic caretaker' discourse is still dominant in Ghana, research has documented that gender relations in the household have to some extent been amended in practice (Boni, 2002; Clark, 1999; Nave, 2017). As long as 20 years ago, Gracia Clark (1999) and Stefano Boni (2002) showed how women negotiated the performance of household duties, such as cooking, in exchange for the provision of economic resources for the family. Studies from the last ten years have similarly noted the growing expectation of men to do domestic work (Ampim et al., 2020; Bougangue and Ling, 2017; Ganle, 2015; Kwansa, 2012). Existing studies argue that young men, men in monogamous relationships, educated young men and men in urban areas are likely to be less patriarchal and are more accepting of men performing domestic duties that are culturally marked as feminine (Bougangue and Ling, 2017; Arnot et al., 2012; Kwansa, 2012). Such emerging studies have primarily been conducted in urban settings and do not examine how shifting gender practices in the household are negotiated and potentially resisted.

Our study attempts to expand the discussion of evolving evidence of gender transgression in household arrangements using qualitative data from urban and rural contexts. We explore how Ghanaian couples 'do gender' (West and Zimmerman, 1987) in the household during pregnancy. The pregnancy period is our study's focus because this period has been documented as a time when gender norms in the household setting may be reworked irrespective of cultural expectations (Carter, 2002a; Carter, 2002b; Gutmann, 2007). Against the backdrop of these adjustments in gender practice, we shed light on the negotiations that take place between men and women concerning housework performance and the possible implications of men's temporary participation in domestic chores in the Ghanaian context. Based on our study material, we provide insights into modifications of gender relations in the household as well as resistance to such transformations and discuss how these contrasting patterns may influence the broader global agenda of seeking gender equity in the performance of unpaid domestic labour.

'(Un) doing gender' and the (re)distribution of household labour

Candace West and Don Zimmerman's work (1987) revolving around the concept of 'doing gender' remains a ground-breaking theoretical framework that has inspired further theorisation about gender. The 'doing gender' framework elevated the understanding of gender beyond personal characteristics by theorising gender as a product of social acts that are recurrent in people's interactions with others (Risman, 2018; West and Zimmerman, 1987: 129). West and Zimmerman (1987: 127) argue that gender constitutes the enactment of practices, behaviours, and attitudes that are deemed socially/culturally appropriate for maleness or femaleness. Hence, gender is not a role, something we are, or a set of features. Instead, gender is something that we are expected to achieve, and people are critically assessed when they adhere to or deviate from appropriate gendered norms, indicating that 'doing gender' is unavoidable (Fenstermaker et al., 2002; Hollander, 2018; West and Zimmerman, 1987). Moreover, this framework points out that gender is done in space and time. Actions and interactions are judged as gender-appropriate or gender-inappropriate within a particular local context (West and Zimmerman, 1987: 135; Hollander, 2018). Thus, as society transforms, practices and interactions will be modified accordingly.

Researchers have problematised the manner in which the 'doing gender' framework has been adopted in empirical studies to explicate how gender norms persist rather than how they transform. In her article 'Undoing Gender', Francine Deutsch (2007) argues that although the original formulation of the framework includes both conformity and resistance to gender norms, 'doing gender' has been commonly misinterpreted as a concept of frozen gender codes and as such, conceals acts of resistance. According to Deutsch (2007: 121), small acts of gender transgression can expand individuals' space of action and inspire others. She encourages researchers to search for processes of both doing and undoing gender to generate discussions

of how the gender system could be destabilised, thus heightening the pursuance of gender equality.

Similarly, Barbara Risman argues that 'doing gender' has been misappropriated as a concept that underscores a binary organisation of women's and men's spheres in the household and posits that this adaptation does not support the feminist agenda of attaining equality in the domestic sphere (Risman, 2009: 82). New kinds of gender-appropriate behaviours may evolve as societies transform. Additionally, people may display behaviours that do not follow the local cultural script (Risman and Davis, 2013: 741-742). Hence, researchers should investigate both acts that conform to cultural ideals in the local context, i.e., 'doing gender,' and acts that do not follow the local gendered expectations, which is categorised as 'undoing gender' (Risman and Davis, 2013: 742).

'Doing gender' presents a starting point to illuminate the culturally expected distribution of tasks among women and men in the Ghanaian household. In line with Deutsch (2007), Risman (2018; 2009) and Risman and Davis (2013), we find it equally important to probe alterations in the cultural repertoire and explore when and how the distribution of household labour is degendered. The primary purpose of this article is to examine how gender is done in the household when couples are expecting a baby and identify the extent to which acts of gender transgression may potentially take place during this peak in the reproductive lives of Ghanaian couples. We analyse the (re)distribution of household labour between intimate partners and discuss men's and women's perceptions, expressed experiences, and practices of distributing tasks and negotiating gender relations in the household.

Materials and methods

The empirical material presented in this article is part of a qualitative study that the authors conducted to elucidate the dynamics between local gender norms, household gender relations, and men's involvement in the care for their partners and households during pregnancy. We gathered data through semistructured interviews and focus group discussions (FGDs) supplemented with observations in Accra, Ghana's capital, and in a rural community anonymised as Sakora, located in the Afram Plains North District of Ghana between June 2017 and May 2019. One key goal of the broader study from which the data for this article are drawn was to explore men's participation and experiences in maternity care services. Subsequently, maternity clinics were a convenient source for identifying expectant mothers and fathers and observing men's engagement in maternal healthcare services. Accra participants were recruited from the maternity and child welfare clinics of a government-owned and managed hospital. In Sakora, we recruited participants from the community through the Community-based Health Planning Services (CHPS) compound. We selected these two locations to facilitate a comparative analysis of rural and urban perceptions, expressed experiences, and practices surrounding men's responsibilities during pregnancy.

The inclusion criterion for men was first-time expectant fathers, which was chosen to allow an exploration of their before and after parenting expectations and experiences. This inclusion criterion for fathers was appropriate in Accra, but in Sakora, where many first-time expectant fathers were teenagers living separately from their partners, this criterion was challenging. Thus, except for one father, the participating expectant fathers from Sakora already had children during the data collection period. The women who participated in the study were expectant mothers and mothers with children and comprised both partners and nonpartners of men who participated in the study. 11 men and 24 women (seven of whom were partners of the male participants) were recruited in Accra. Twelve men and twelve women (eight of whom were partners of the male participants) were recruited in Sakora.

According to the 2010 National Population Census, 92.6% of men compared to 91.8% of women were engaged in economic activities in Accra (GSS, 2013: 76). The Accra male participants, aged between 28-39 years, worked outside the home as traders and artisans or in the formal sector as sales personnel and in occupations such as graphic design. The Accra female participants, aged between 18-51 years, worked primarily as artisans and traders, and a few worked in the formal sector. All female partners of the Accra male participants were engaged in economic activities outside the home. The fertility rate in Accra was estimated at 2.5 in the 2010 census (GSS, 2013: 64). Among our Accra female participants, 11 were first-time expectant mothers, and 13 had between one and three children.

All participants in Accra lived in a nuclear family structure. The housing composition of the Accra participants were of three different kinds: houses with private compounds, bathrooms and kitchens; apartments with shared compounds but with private bathrooms and private kitchens; and apartments with shared compounds, shared bathrooms, and shared kitchens.

The 2010 National Population Census indicates that 98.7% of men compared to 98.4% of women were engaged in economic activities in the Afram Plains North District (GSS, 2014a: 33). All our participants in Sakora worked as farmers, and a few supplemented farming with petty trading and the provision of motorcycle transport services. All female partners of the Sakora male participants were engaged in economic activities outside the home. The age range of the participants in Sakora was 21-48 years for men and 18-48 years for women. The fertility rate in the district was estimated at 4.2 (GSS, 2014a: 18). Except for two women who were first-time expectant mothers, our female participants in Sakora had between one and four children.

In Sakora, married or cohabiting couples lived together in privately owned (small) houses. It was common to find two or more small houses of nuclear families from the same kin group located on one common compound. It was also common to share cooking spaces and bathrooms

with members of the same compound or/and members of other compounds. Thus, some coparents lived alone, while others lived as part of an extended family and yet others lived in a connected series of households.

We collected data using semistructured interviews, FGDs and observations. As the primary participants of the study, the men were scheduled to be interviewed to describe their domestic tasks and responsibilities when they were expecting a baby. In total, we conducted 22 semistructured interviews with men and three with women in Accra and Sakora. Qualitative interviews provided participants with the opportunity to share their own experiences and potential changes in practical routines during pregnancy. The women were to be engaged in FGDs to gather a broad range of opinions on the forms of household-related support that they expected and received from their partners when they were pregnant. Each FGD consisted of five to ten participants. We facilitated five FGDs with women and one with men. Although we scheduled FGDs with only women, one FGD was facilitated for men in Sakora. We found that the men in Sakora discussed their experiences, practices, and perceptions about men's responsibility in the family more openly during the FGD than during interviews.

Both the interviews and FGDs centred on four key areas: fatherhood and masculine norms within the Ghanaian social context; expecting fathers' responsibilities during pregnancy; the practical daily routines of expecting fathers; and the forms of social support for expecting fathers and their nuclear families. One of the questions in FGDs with women focused on their expected and received support from partners during the time of pregnancy. Women reflected on this question citing their personal experiences as examples. Both the FGDs and interviews lasted an average of one hour and were conducted in Twi and English. Discussions and interviews in Accra were conducted at the health facility, at the homes of study participants, and at meeting places in the city. In Sakora, interviews were conducted in participants' homes, and FGDs were conducted under a shed in the village square.

Interviews and discussions were supplemented with observations at the selected hospital's premise in Accra and at some of the participants' homes in Accra and Sakora. In Accra, the first author (GAA) observed men's engagement at maternity clinics and in chores that men and women carried out at home. In Sakora, GAA observed the daily activities of the residents in the village, for example, what men and women carried from the farm, what chores they performed in their households, and how they spent time in the evenings after farm work. GAA also engaged men and women in the village in informal conversations related to the topics under study.

The educational and social background of the researcher influenced data collection for the study. As GAA was known to the participants as a student in Norway, men in Accra sometimes compared social norms in Ghana to perceived social norms in Norway during the interviews. In Sakora, participants tended to compare social norms in the village to perceived social norms in Accra, since GAA was known as residing in Accra and schooling in Norway. Despite the implications of her position as a student of higher learning, interaction with participants during interviews and FGDs was largely informal and relaxed. The exception emerged during the semistructured interviews with men in Sakora. Engagements with men during these interviews were more formal in nature and did not generate in-depth reflections. The formal character of the interaction between GAA and men in Sakora could be related to the men's discomfort of discussing their personal lived experiences with a young woman from Accra. It was likely that this category of men did not readily perceive GAA as someone who could relate to their experiences.

As we have already indicated, the FGD with men generated more in-depth discussions and sharing of personal experiences. This could be related to one of the advantages associated with FGDs in the methods literature: they facilitate an atmosphere where group members influence each other in a manner where it becomes easier and 'natural' to share personal stories (Green

and Thorogood, 2018: 155). It is likewise possible that FGDs provided an environment where GAA became less visible in relation to group members, and thus, participants became more interested in discussing the topics raised than paying attention to the personality and background of the researcher.

Data analysis

With the permission of our participants, all interviews and discussions were tape-recorded, transcribed, and anonymised. The analysis was inspired by Victoria Braun and Virginia Clarks' description of thematic analysis (Braun and Clarke, 2013). Thematic analysis emerged as beneficial in this study because of its applicability to working with data generated from different research methods and sources (Nowell et al., 2017). Interviews and discussions were translated and transcribed by GAA and a research assistant during and after fieldwork. GAA audited all transcripts to ensure language consistency. This process was quite productive since she conducted the interviews and discussions. Key concepts from field notes, interviews, and discussions were recorded into an analytic memo that became the initial resource in the coding process.

After transcription, GAA printed out a few of the transcripts and coded them on paper to develop a coding manual. All transcripts were imported into NVivo software, and GAA coded all the transcripts. She coded the material (in NVivo) based on meaning in significant excerpts of the text, as suggested by Saldaña (2016: 19). A number of adjustments were made during this process where codes were merged to form new codes while others were subsumed under existing codes. Codes that described recurrent topics in the data were merged into categories during later stages of the analysis. After finding categories, GAA printed the overview of the codes and categories and shared them with the coauthors to read, review and discuss multiple

times. Finally, we worked together to search for and agree upon the overarching themes. The findings presented in this paper are based on the full knowledge gained during fieldwork, with a particular emphasis on two of the identified categories: men's responsibilities during pregnancy and motivation for men's involvement in household tasks and care for their pregnant partners.

Ethical consideration

The study was guided by the Norwegian Institute for Data Protection (53570/3/ASF) protocols and received ethical approval from the University of Ghana College of Health Sciences (CHS-Et/M.6 – P1.12/2017-2018).

We presented the study protocols to the health facility in Accra and the Afram Plains North District Health Directorate. In Accra, permission was granted by the selected hospital's central administration, the maternity clinic, and the child welfare clinic. In the Afram Plains, the District Health Directorate approved the study protocols and granted permission for the study to be conducted. We moreover sought and received permission from the leadership of the Community-based Health Planning Services (CHPS) in Sakora.

Written or oral informed consent was obtained from all participants after the purpose of the study was thoroughly explained (Kvale and Brinkmann, 2009). Interviews and discussions were recorded only upon acceptance of consent from the participants. We informed the participants that they could withdraw their consent during the session without any consequences and that information gathered during the study would remain anonymous. All participants were given pseudonyms upon the transcription of the data.

Findings

The study findings are organised in two parts. The first part seeks to outline expectant fathers' practical responsibilities in the household in Sakora and Accra and illuminate apparent changes in tasks performed by men and women during pregnancy. The second part explores our participants' perceptions and accounts of ostensible tensions that emanate from men's involvement in domestic work.

Practical male responsibilities in Sakora households

In Sakora, farm work usually began before sunrise, and by 6 am, most farmers were already headed to their farms located in the outskirts of the village. Couples usually managed their separate individual farms (sometimes in the same field), and men and women commonly cultivated different crops. For example, in one household, while the husband produced diverse crops such as maize, yams, and vegetables, the wife grew only cassava. Most men spent long hours each day working on the farm. It was also common among farmers in the village to have a farmhouse in their fields where they would stay for several days a week. Even if women cultivated their own crops and thereby contributed to household income, the participants' narrative of men's and women's responsibilities in the household was largely consistent with the dominant gendered pattern of 'male breadwinner' and 'female domestic caretaker'. Men were expected to provide the family with material and financial resources, while women were expected to cook, wash clothes, care for children, and fetch water and firewood. One male participant summarised men's responsibilities as follows:

Well, mostly what people expect is that the man would be able to cater to the woman's hospital bills and provide the children's clothes and shelter. Those are what people expect from men (Kwabena Yeboah, 36 years old, Sakora).

As providers for their households, men performed more work on the farm and therefore were not expected to be involved in domestic work as indicated in the excerpt below:

In this community, our primary source of livelihood is farming. Men here have more problems than women because we do not have any other business in the community apart from farming. So as a man, if I go to the farm, you will realise that the workload on me is more than that of the woman, but if I come home and there is some work to do, I would be willing to do that if I am not tired (Yaro, 48 years old, Sakora).

However, during their partner's pregnancy, men were expected to do housework. Both men and women expected men to carry out domestic chores during their partners' pregnancy, and there were no differences in tasks that men and women expected men to perform. Men were expected to cook, fetch firewood from the farm, fetch water from the community borehole, and even nurture the farms that women usually cultivated. Other fathers acknowledged that during pregnancy, women could be more tired than usual and need the support of their partners to perform housework.

We carry firewood into town. Although people laugh at us, we never give up, we still do. We do a lot to support our wives. Sometimes I would get home with the foodstuffs and then go straight into the kitchen to prepare food for us. You know when a woman is pregnant, she becomes a little weaker than her usual strength, so I do my very best to support her at home (Kwakye, 39 years old, Sakora).

Fetching firewood from the farm was noteworthy in this narrative because people in the community would identify it as a feminine task. Moreover, participants who stayed at the

farmhouse for several days a week tried to make up for the time away from home, as one pregnant mother recounted:

For instance, my husband is not always around [that is, he is on the farm], but he makes sure that he helps me with the housework whenever he comes. He is the one who sweeps the house and sometimes washes clothes by hand. I cook and bathe the children, so we share the work and that is how it has been for us (Mawuena, 31 years old, Sakora).

Participants stated that men who engaged in housework, such as fetching water, carrying firewood, and cooking, were at times ridiculed as doing 'women's work', and their partners were accused of bewitching them. This can be seen, for example, in Kwakye's quote above. Our study participants indicated that some men were discouraged from performing housework because of such negative comments. For example, Patricia said the following about men doing housework:

Some people start thinking the woman has charmed him or something, because it is not the norm in this community, men are not expected to do such works. When the men do the things and later hear such comments from town, they start acting differently (Patricia, 25 years old, Sakora).

Nevertheless, most of the male participants held that community members' teasing did not prevent them from doing housework. One father Asiedu, for example, said, '*She is my wife. How I treat her depends on me. I will not listen to anyone or make decisions according to what they say. This is my family'*.

Similarly, Yaro said,

As for me, if I want to help my wife in the house or do any form of housework, I do not pay attention to what people would say or do because I do not have time to go to people's houses to see what they do for their wives, so what is the point of paying attention to what they would say? I only focus on what I can do for my wife and family.

Yaro continued to emphasise that he did not believe that social ridicule would influence men because what they did was their own decision.

I do not think anything is preventing them. Some minutes ago, we saw a man carrying his baby on his back [referring to a man who passed by during the interview], so I do not think there is anything that prevents us. It is a choice.

When GAA visited Yaro's home a few days later, he and his pregnant wife were cooking together in their open compound. Most mothers also confirmed that their partners' tasks during pregnancy were not determined by what other people said.

When I was pregnant, from my seventh month, I could not go to the farm. My husband was the one going to the farm and doing everything for us. If he were to follow what people say, he would not have done that, and I would not know whom to turn to (Julie, 30 years old, Sakora).

Most men in the village did not attend maternity care services and barely discussed what happened at the clinic with their partners. Men did not see the need to accompany their partners for maternity services unless health workers specifically invited them.

Above, we have demonstrated that men in Sakora carried out domestic chores when the family was expecting a child. In performing household duties, men and their partners were not free

from accusations and judgement for enacting 'inappropriate' gender behaviours. However, the men framed their activities within the household as a choice that was independent of cultural norms. In the next section, we consider the practical household routines of the men in Accra during their partner's pregnancy.

Practical male responsibilities in Accra households

Among our study participants in Accra, it was common that both men and women worked outside the home for long hours daily. Although both men and women engaged in economic activities and therefore contributed to the family's income, men were consistently described as the primary breadwinners. In contrast, women were said to be responsible for the bulk of household chores. One mother summarised these expectations in the following way: '*In our society, the principal responsibility of a father or a man is taking care of the family's financial needs. Customarily, the woman is the one who is supposed to do the domestic chores of the household*' (Agnes, 51 years old, tailor, Accra).

However, women mentioned that current family dynamics in the city would be difficult to navigate without men's help with housework. Indeed, they admitted that men's performance of domestic chores during their partners' pregnancies was expected and quite common and provided examples of tasks that their partners would commonly perform. Lizzy, for example, said, '*My husband also does many things at home. He washes clothes by hand, cooks, and all that. When you both help in doing the housework, there are fewer problems* (Lizzy, 36 years old, hairdresser, Accra).

The Accra female participants said that women could become tired quickly during pregnancy or sometimes experience complications and would hence be unable to carry out housework.

Consequently, men were expected to take up most of the housework. One man recounted that he took over the bulk of the domestic chores from the second trimester of his wife's pregnancy.

She [his wife] used to do all the household chores, but I told her not to do those things anymore for about three months now. I do not want her to be doing anything stressful, so I do not allow her to do anything at home, such as washing clothes and cooking. I do not let her wash or cook (Derrick, 32 years old, truck driver, Accra).

Other expectant fathers expressed similar views and mentioned that they assisted their partners with household chores such as cooking, cleaning the house, and washing clothes at the time of pregnancy. '*I do not like washing. I cook, although, since she [his wife] cannot be standing for now, I must be the one doing the washing. I do not have any choice. So I am doing my best*' (Charles, 30 years old, graphic designer, Accra).

Similar to the study participants in Sakora, the male participants from Accra mentioned that they could be teased for doing housework. Men such as Derrick preferred to perform these chores out of friends and family's sight to avoid social ridicule:

A friend came to my house and saw me washing and started making some comments. That is why I always do not like people seeing me doing what I do in my house to support my wife. People talk so much about other people's privacy and what they do. You know, people make negative comments, and they may sometimes be convincing, so I do my thing privately.

From Derrick's statement, we come to understand how people's comments or ridicule when they see men doing housework can at times discourage some men from carrying out such

chores. Unlike Derrick, who felt uneasy about his friend's comments, most of our male participants in Accra believed that doing housework depended on themselves and their love for their partners rather than on expected social norms, as one father indicated:

You do it because you love her. If you love your partner, it does not matter. It would help if you shared the responsibilities, whether they are meant for women or not. Sometimes men would see that their wives are going through a lot during pregnancy, but they refuse to help. It is their lifestyle, and it is not about what men are expected to do or not do (Thomas, 39 years old, commercial driver, Accra).

The women also talked about how love motivates men to support their partners by doing housework: *'Some [men] do it [housework] because of the love they have for their wives, but do not see it as their responsibility'* (Adwoa, 39 years old, petty trader, Accra). Another woman similarly said*, 'If you show the man how you love him and how you both understand each other, the man will always listen to you when you ask him for help with housework'* (Lizzy, 36 years old, hairdresser, Accra). Women continued to describe men who loved their partners as interested in building their families and spending their nonworking hours at home with their partners. These accounts are indicative of the role of love in inspiring male participation in household chores.

The research material from both Sakora and Accra contains accounts of practical tasks that men perform in the household during the period of pregnancy, and hence, it appears that the period of pregnancy entailed flexibility in local conventional gender norms in the household. According to the participants' accounts, men engaged in housework to support their pregnant partners, who may be more physically fatigued than usual or could experience complications

during pregnancy. The men simultaneously constructed themselves as self-determined by accentuating that doing housework was a choice they made, solidifying their image as autonomous subjects.

'The lazy woman': Perceived implications of men's short-term performance of housework

This section moves from individual couples' practices to discussions about general social standards and their implications on the extent to which transgressing gender norms are permissible. It is interesting to observe that although Sakora and Accra have different socioeconomic setups, the gendered cultural expectations of household arrangements that the participants in each location presented were similar. In both contexts, our participants emphasised that men's primary responsibility was to provide financial resources for the household. The participants' accounts exhibit a certain resistance towards a more permanent transformation of the normative pattern in the divisions of household labour. Men were envisaged as performing housework to support physically tired expectant partners but were expected to not take over the primary responsibility for doing domestic chores either during pregnancy or afterwards.

The participants in Sakora contended that an increase in men performing housework could encourage laziness among women. Providing examples of this, the women in Sakora recounted how some expectant mothers neglected their domestic duties because their partners performed these duties.

Sometimes, it is the fault of some of the women. When the man starts doing the housework, they leave all the work for him to do. Because they know that, after all, the man is helpful, so even

when the woman does not do it, the man would. When the man refuses to do it, they get angry. It is a very bad attitude. It must stop (Doris, 45 years old, Sakora).

Another woman, Julie similarly said:

Others, too, can do the work all right, but they like to be pampered, and laziness sets in, so they burden the men. Honestly, some women are so lazy. Although we all advocate for men's support, some women take advantage of that to become lazy. They would leave all the work for the men. [Laughing] Some are lazy. Since they know that the men would do it, they would find ways to use sickness as an excuse to leave the work for the men. As we speak on our behalf, we should also speak for the men. Because some are very helpful, they make sure that they take good care of their wives (Julie, 30 years old, Sakora).

Julie's account inferred that when an expectant mother is not physically tired or does not encounter health complications, she should not relinquish domestic duties to her partner. Many of our male participants in Sakora similarly talked about women becoming too comfortable with men doing housework, even after childbirth.

Some women also become used to the support you give them during pregnancy and would always expect us to do the work for them. Instead of sharing responsibility, she would rather let you be the one to do all things. That attitude is not good (Kojo, 27 years old, Sakora).

This view reinforced that of other men who said that housework was not a man's duty but a form of support given during pregnancy. However, women were reported to continuously demand that their partners perform housework, which made some men agitated. One father explained:

I truly help my wife at home, but sometimes she is the one asking and demanding that support. You know, we share the responsibilities, but it becomes too much sometimes. It is not nice at all. Just because we do these things does not mean they should take advantage to misuse us (Phillip, 28 years old, Sakora).

In contrast to the descriptions of men's household contributions in Sakora, the women in Accra claimed that men's performance of domestic work should already be part of the household routine before a pregnancy. Indeed, they acknowledged that many men in Accra were involved in domestic chores. However, and similar to the narratives of the women in Sakora, the women in Accra emphasised that shifting the bulk of domestic duties to men because of their willingness to be supportive could present a danger to the 'normal' balance of gendered household labour. Adwoa, for example, said, *'I think it is the fault of the women sometimes. When some women realise that the men are helpful, they start leaving all the work for the men to do'* (Adwoa, 39 years old, petty trader, Accra).

Other female participants in Accra claimed that women should prove themselves hardworking to access their partner's help with household chores. Cecilia (32 years old, administrator, Accra) stated, '*It depends on how you both started in the relationship. When he knows that you are hardworking, he will always be available to help when you are tired*'.

The data from Accra revealed that, similar to the findings in Sakora, the men described some women as lazy and said they intentionally avoided housework during pregnancy and not because they were tired or experienced complications, as Elorm summarised:

Some women can do it [housework], but they are lazy. Even though they can do it, they will not do it because of laziness. That is why I said there should be some education to teach them that this laziness does not help. So some of these women must be advised. It is very bad, and they must change. Some women do not like doing things. They know they can do it, but they refuse to, with the excuse of being pregnant. It is just not acceptable. I think it must change (Elorm, 30 years old, artist, Accra).

Elorm's view was consistent with that of other men who believed that women should not neglect their domestic responsibilities because men are willing to support them during pregnancy. Eric, for example, held the view that women will not receive support from their partners if they neglect simple tasks such as sweeping. He said, '*Some women are lazy. They are so lazy. Once they are pregnant, they stop doing virtually anything. If you expect the man to do even the sweeping for you, then the man would not give you the help you need'* (Eric, 30 years old, sales executive, Accra).

It can be extrapolated from the research material that the participants recapitulated normative gendered scripts that define housework as 'women's' work. Although the accounts from the Accra participants reveal that couples there share household chores on a more regular basis, in both study contexts, housework emerges as strongly gendered. Another dimension of the participants' accounts is the unabated understatement of women's participation in paid labour and hence the taking for granted of their contribution to the household's financial resources, which again emphasises male breadwinner and female domestic caretaker ideals.

Discussion

This article has endeavoured to contribute to the global debate about increasing male participation in unpaid domestic work (Barker, 2014). Although conventional gender norms are still tenacious, emerging social research has presented examples of more egalitarian household arrangements in Sub-Saharan Africa (Comrie-Thomson et al., 2019; Doyle et al., 2014; McLean, 2020; Mkandawire and Hendriks, 2019; Smith, 2015). The present study underlines a series of apparent ambiguities in the temporary adjustment of culturally prescribed household gender norms in Ghanaian couples' lives when they are expecting a child.

The findings exemplify that 'doing gender,', that is , following culturally appropriate gender norms, in both Accra and Sakora implied that men were expected to provide their families' financial income (West and Zimmerman, 1987). In contrast, women were seen as responsible for the bulk of the domestic chores, even if they worked full time outside the home to earn an income. These are the norms that men and women are held accountable to in their daily lives and are necessary for achieving the position of a 'proper' man and a 'proper' woman (Hollander, 2018; West and Zimmerman, 1987). Remarkably, women's participation in paid labour or farming and their contribution to the household's income were not, on a normative level, considered in this male-female equation. Female accountability was limited to the performance of domestic tasks only. Nonetheless, the time of pregnancy was distinguished as a period when doing household chores became less gendered. The male participants from both urban and rural areas actively engaged in housework during their partner's pregnancies. In Sakora, although the men did not accompany their partners to maternity care services, they washed clothes, cooked, swept, cleaned, fetched water and firewood, and performed farm work on their partner's behalf. Similarly, the men in Accra cooked for their families, washed clothes, and cleaned the house, in addition to attending maternity care services with their partners (See also; Ampim et al., 2021).

Our study findings resonate with research in Ghana that conveys the developing reworking of gender relations within the household (Ampim et al., 2020; Bougangue and Ling, 2017; Kwansa, 2012). It has been argued that educated urban men are less patriarchal and more accepting of men performing household tasks that are typically considered feminine (Arnot et al., 2012; Bougangue and Ling, 2017; Ganle, 2015). Similarly, men in rural areas have been noted for upholding deep-rooted sociocultural practices that preserve unequal gender norms (Dako-Gyeke and Owusu, 2013). Our research material appears to illustrate that despite the sociocultural differences in rural and urban areas, during the period of pregnancy, men in both settings are willing to modify their daily activities to incorporate far more household chores.

A pertinent question that we raise based on our study findings is whether altered gender norms and practices at the time of pregnancy suggest that new ways of 'doing gender' are unfolding and that gendered relations are in the process of transforming (Deutsch, 2007; Risman and Davis, 2013; West and Zimmerman, 1987). It is vital to reiterate that both urban and rural male and female participants repeated that the primary responsibility of men was breadwinning. Women's participation in paid labour or farming and their contribution to the family income were obscured and were not included in the division of labour between the spouses. The observed shift in gender relations thus principally concerned men's participation in domestic chores to support pregnant partners. In this regard, the context of pregnancy generated circumstantial progress towards what has been called gender equality-oriented household arrangements (Bloksgaard et al., 2015).

The present study findings demonstrate that these acts of revision of household gender relations were tentative and temporary. Men's 'excessive' involvement in domestic work was perceived as potentially creating imbalances in household labour distribution. This perception is partly allied to institutionalised and socially structured assessments of what makes a 'proper' man and a 'proper' woman. Irrespective of women's participation in waged labour and their

contributions to household income, studies from Ghana have shown that divisions of household labour are described according to male breadwinner and female domestic caretaker ideals (Atobrah and Ampofo, 2016; Boni, 2002; Clark, 1999). This thus appears to be the pattern of gendered divisions of labour that men and women are held accountable to, a pattern that was also reflected in the narratives of our study participants. This implied that men were not expected to accomplish gender through the performance of housework; hence, doing most of the housework did not enhance their social status as men. Women were first and foremost appraised according to the performance of housework and not according to their involvement in paid labour and contribution to household income. Hence, when their male partners engaged actively in housework, women runned the risk of being seen as lazy, thereby diminishing their social achievements as women. By implication, a woman's participation in paid employment is not considered important for the performance of gender; rather, it is essential that she accomplishes gender by doing housework (Fenstermaker et al., 2002).

Hollander (2018) explains gender accountability as hidden until people behave in ways that are deemed inappropriate for their assigned sex category. Moreover, gender accountability precedes actions since people are guided by anticipated reactions in lieu of the actual reaction (Hollander, 2018: 177). In anticipation of negative reactions from family, friends and others to gender transgressions in the domestic arena, our participants were eager to present men's involvement in domestic chores within the contours of providing support for a physically fatigued expectant mother. The participants' circumspection about who performs housework even during peak reproductive periods accentuates the pervasiveness of gender assessment in contexts where gender practice appeared to be more flexible. The way that gender accountability seemed to influence men's and women's actions in the research material is consistent with the assertion that 'doing gender' is ubiquitous (Hollander, 2018; West and Zimmerman, 1987).

An additional explanation for our participants' critique of men's 'excessive' involvement in domestic work is that it could potentially disrupt the social order. Another Ghanaian study has similarly shown how women who transgressed into breadwinning responsibilities were perceived as distorting the social regulations within a community (Tolhurst et al., 2008). In their research in a rural Ghanaian community, Rachel Tolhurst and colleagues (2008) found that the more economically independent women became, the more likely it was for men to neglect their responsibility for providing the family's income. Consequently, women themselves called for a shift back to the typical arrangement, where men were the primary breadwinners and women carried out the bulk of the household chores (Tolhurst et al., 2008: 1115). Silberschmidt's (2001: 665) study in Tanzania similarly demonstrated that when women provided more of the family's income than men did, the latter tended to adopt aggressive behaviours or engage in extramarital relationships and overuse alcohol to reaffirm their masculinity. Drawing on these examples, our study suggests that men and women may resist radical transformations in gender practices to avoid the distortion of established social arrangements.

Our research material exemplified that hegemonic masculinity (Connell, 2005) is powerful in operation, where male participants' involvement in housework was configured within a narrative of choice (Bach, 2017) , i.e., men can decide to contribute, but women should not ask them to. When men commented that their participation in housework could be mocked as nonconforming with cultural standards, they again elicited the narrative of choice. In this way, the men constructed themselves as self-determined subjects with control over their decisions and households, congruent with dominant notions of masculinity in the Ghanaian context (Adomako Ampofo and Boateng, 2007).

As presented in this article, the revisions of gendered divisions of household labour correspond to what scholars have termed short-term responses to demanding life changes (Dermott and Miller, 2015: 185). Feminist scholars have warned that temporary shifts in gendered provisions

in the household should not be readily interpreted as an indication of change because they could be related to the 'personal traits' of the people involved (Bach, 2017: 352). However, as Deutsch (2007: 121) has argued, small acts of transgression, whether related to personal traits or performed during exceptional circumstances, may expand peoples' space of action and motivate others. Following Deutsch's argument, even slight alterations, such as men expanding their uptake of domestic work during their partners' pregnancy, may amount to some degree of 'undoing gender' in the household (Deutsch, 2007). Moreover, men who participate in housework during pregnancy will learn the skills and may more readily engage in household chores beyond the period of pregnancy. Men who engage in domestic chores during the peak reproductive periods may also realise that doing additional household tasks does not entirely undermine their masculine roles in the family setting and subsequently feel more comfortable with the prospect of continuing to do more housework.

Our findings show that both men and women, especially in the urban area, drew on love as a propelling argument to explain (and defend) men's propensity to do housework. The participants discussed love as an element that could help men to disregard social mockery and oppose sociocultural gender norms. The accounts of love in this research material reverberate with the findings of a study conducted in Tanzania and Zimbabwe, which contended that men's participation in household chores was significantly connected to improvements in couples' relationships (Comrie-Thomson et al., 2019: 734). Feminists have identified love as a component in the negotiation and contestation of gender relations among young couples and argued that love should be researched when exploring men's involvement in maternal and child healthcare (Comrie-Thomson et al., 2019: 734; Bhana, 2013; Deutsch, 2007). Our participants' discussion of love corroborates the argument that young couples' relationships create a space where men and women can navigate new ways of doing gender (Comrie-Thomson et al., 2019).

Conclusion

This article has aimed to contribute to existing social research in Ghana and Sub-Saharan Africa on the seeming relaxation of gender norms encompassing the domestic sphere. The research material underscores the anticipation of modifications and actual changes in culturally expected gender practice in the household during peak reproductive periods. Although the documented changes appeared to be primarily of a temporary nature, men's active participation in housework during the time of pregnancy suggests that women would spend relatively less time doing domestic chores and thereby have less of a workload. The findings also imply that the period of pregnancy presents an opportunity for the introduction of gender equality norms in the household. Men who actively participate in housework during their partners' pregnancy could be used as role models to facilitate peer education in their communities. However, initiatives designed to introduce gender-equal norms should be contextualised and formulated to coincide with what communities prioritise as important.

Further research would be beneficial to facilitate the exploration of more permanent changes in gender practices beyond the time of pregnancy. For example, an investigation of men's performance of housework after childbirth, that is, during the postnatal/neonatal period, would be valuable to show indications of continuation or withdrawal of men's active participation in housework beyond the time of pregnancy. Additionally, research on multiple stages of parenting, such as first-time parenting, parenting when couples live separately, parenting during cohabitation, and parenting during marriage, could illuminate the influence of family formation and relationship stability on gender practices in the household. More context-based research on when practices become less gendered in households could enhance suggestions on effective ways to promote broader global goals of gender equality and equity.

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APPENDICES

Appendices

Appendix I: Ethical review and clearance

Appendix II: Informed consent letters

Appendix III: Semi-structured interview guide for expectant fathers

Appendix IV: Focus group discussion guide

Appendix V: Semi-structured interviews with health workers

Appendix VI: Semi-structured interviews with new fathers

Appendix VII: Sample of thematic analysis for the three peer-reviewed articles

APPENDIX I: Ethical review and clearance

Haldis Haukanes
HEMIL-senteret Universitetet i Bergen
Christiesgt. 13
5015 BERGEN

Vår dato: 27.04.2017 Vår ref: 53570 / 3 / ASF Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 10.03.2017. Meldingen gjelder prosjektet:

53570	*Transforming gender relations? Male involvement in maternal and infant health care in Ghana. A qualitative study*
Behandlingsansvarlig	*Universitetet i Bergen, ved institusjonens øverste leder*
Daglig ansvarlig	*Haldis Haukanes*
Student	*Gloria Abena Ampim*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvernombud/meld_prosjekt/meld_endringer.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 29.09.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Amalie Statland Fantoft

Kontaktperson: Amalie Statland Fantoft tlf: 55 58 36 41
Vedlegg: Prosjektvurdering
Kopi: Gloria Abena Ampim Gloria.Ampim@uib.no

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 53570

PURPOSE
This study explores the extent to which male involvement in maternal and infant health care could influence notions of masculinities and practices of fatherhood as well as challenge dominant gendered structures and inequalities in urban and rural contexts.

INFORMATION AND CONSENT
The sample will receive written and oral information about the project, and give their consent to participate. The letter of information is well formulated.

Also third persons (the wives/partners of the informants) will receive written and oral information about the project, and give their consent to participate. We received a letter of information on email 25.04.2017, and we find that it is well formulated.

SENSITIVE DATA
Because of the purpose of the project, we find that it is likely that sensitive information relating to health will be registered.

DATA SECURITY
The Data Protection Official presupposes that the researcher follows internal routines of Universitetet i Bergen regarding data security.

END OF PROJECT
Estimated end date of the project is 29.09.2017. According to the notification form all collected data will be made anonymous by this date.
Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:
- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such as residence/work place, age and gender)
- digital audio files

UNIVERSITY OF GHANA
COLLEGE OF HEALTH SCIENCES
ETHICAL AND PROTOCOL REVIEW COMMITTEE

Ref. No.:..... 2nd March, 2018

Gloria Abena Ampim
Dept. of Health Promotion and Development
University of Bergen
Norway

ETHICAL CLEARANCE

Protocol Identification Number: **CHS-Et/M.6 – P1.12/2017-2018**

The Ethical and Protocol Review Committee of the College of Health Sciences on the 1st of March, 2018 unanimously approved your research proposal.

TITLE OF PROTOCOL: **"Transforming Gender Relations? Male Involvement in Maternal and Infant Health Care in Ghana"**

PRINCIPAL INVESTIGATOR: **Gloria Abena Ampim**

This approval requires that you submit six-monthly review reports of the protocol to the Committee and a final full review to the Ethical and Protocol Review Committee at the completion of the study. The Committee may observe, or cause to be observed, procedures and records of the study during and after implementation.

Please note that any significant modification of this project must be submitted to the Committee for review and approval before its implementation.

You are required to report all serious adverse events related to this study to the Ethical and Protocol Review Committee within seven (7) days verbally and fourteen (14) days in writing.

As part of the review process, it is the Committee's duty to review the ethical aspects of any manuscript that may be produced from this study. You will therefore be required to furnish the Committee with any manuscript for publication.

This ethical clearance is valid till 2nd March, 2019.

Please always quote the protocol identification number in all future correspondence in relation to this protocol.

Signed: .....

PROFESSOR ANDREW A. ADJEI
CHAIRPERSON, ETHICAL AND PROTOCOL REVIEW COMMITTEE

cc: Provost, CHS
Dean, University of Bergen
Head of Department

APPENDIX II: Informed consent letters

Request for participation in research project:

Transforming gender relations? Men's involvement in care for their partners and households at the time of pregnancy in rural and urban Ghana. A qualitative study

PI: Gloria Abena Ampim

PhD Candidate with University of Bergen (UiB)

Information letter for fathers and mothers

Background and Purpose

The purpose of this project is to understand how men and women think about fatherhood, fathers' experiences and practices during pregnancy and care for infants and also their experiences of programmes which are designed to support them to cope with pregnancy and parenting. It is a PhD project at the University of Bergen, Norway and is also funded by the University. Topics to be covered will include: how men and women understand fatherhood; some of the social expectations of fathers in Ghana; how men support their partners during pregnancy; men's experience of antenatal care and post-natal care; and men's experiences of pregnancy schools or other programmes they are involved in; and factors that are considered in designing programmes for men.

Your partner and you have been selected to participate in this study because you are first-time expectant parents.

We will have an interview for approximately 60-90 minutes during which I will seek your understanding on the topics mentioned above. During the interview, I will take notes of answers and audio record ONLY if you permit me to.

Your name and personal details and that of your partner will not be recorded. At the end of the interview, if you both will like to participate again after the birth of your child, then I will record your contact in order to reach your partner for a second interview. Your contact details will be treated confidentially and separate from the information I receive, therefore, it will be stored separately from the data so that it cannot in anyway be linked to you. After the second interview, your contact details will no longer be stored.

The information shared in this interview will remain confidential and only supervisors and myself will have access to it. The data will also be anonymised and in publications, information will not be linked to any participant. The project is scheduled for completion by the end of 2022. Throughout the project, the data will be anonymised and after completion, the project team will store the anonymous version of the data.

Voluntary participation

It is voluntary to participate in the project, and if you do not agree, then your will not participate. After you have both agreed, your partner can at any time choose to withdraw his/her consent without stating any reason. If you do not agree, then she/he will not participate. If she/he decides to withdraw, it will not affect the quality of services you receive at this facility neither will it affect the relationship you have with the health workers.

If you would like to participate or if you have any questions concerning the project, please

contact Gloria Abena Ampim on +4790546807(Norway) or +233 240424472 (Ghana) or Haldis Haukanes on +47 55589259.

The study has been notified to the Data Protection Official for Research, NSD - Norwegian Centre for Research Data and has been ethically approved by the University of Ghana, College of Health Sciences.

You have the right to request access to, deletion/correction/limitation of one's personal data, as well as the right to data portability.

You also have the right to send a complaint to the Data Protection Officer for the data controller or The Norwegian Data Protection Authority.

You can contact the Data Protection Officer on phone number: +47 55 58 21 17

I have received information about the project and am willing to participate.

1. I agree to participate in this interview without audio recording

---

(Signed by participant, date)

2. I agree to participate in this interview and it can be audio recorded.

(Signed by participant, date)

Request for participation in research project:

Transforming gender relations? Men's involvement in care for their partners and households at the time of pregnancy in rural and urban Ghana. A qualitative study

PI: Gloria Abena Ampim

PhD Candidate with University of Bergen (UiB)

Information letter for men and women's focus group discussion

Background and Purpose

The purpose of this project is to understand how men and women think about fatherhood, fathers' experiences and practices during pregnancy and care for infants and also their experiences of programmes which are designed to support them to cope with pregnancy and parenting. It is a PhD project at the University of Bergen, Norway and is also funded by the University. Topics to be covered will include: how men and women understand fatherhood; some of the social expectations of fathers in Ghana; how men support their partners during pregnancy; men's experience of antenatal care and post-natal care; and men's experiences of pregnancy schools or other programmes they are involved in; and factors that are considered in designing programmes for men.

You have been selected to participate in this study because you are parents with small children/expectant parents residing in this community.

We will have a discussion for approximately 60-90 minutes during which I will seek your understanding on fatherhood roles and social expectations of fathers, fathers' experiences and

practices during pregnancy and infant care and societal support for expectant and new fathers. Notes will be taken during this discussion and it will also be audio recorded.

Your names and personal details will not be recorded. The information shared in this interview will remain confidential and only myself and supervisors will have access to it. The data will also be anonymized and in publications information will not be linked to any participant. I will also encourage us all to avoid mentioning people's names when making examples and that we all make an effort to keep the information shared by others during the session confidential.
The project is scheduled for completion by the end of 2022. Throughout the project, the data will be anonymised and after completion, the anonymous version of the data will be stored by the project team.

You will not incur any cost by participating in this study. You will be reimbursed your cost of travel to the location of the discussion.

Voluntary participation

It is voluntary to participate in the project, and you can at any time choose to withdraw your consent without stating any reason. Your decision to withdraw will also not affect the quality of services you receive at this facility neither will it affect the relationship you have with service providers. If you would like to participate, we can schedule an appointment now. If you have any questions concerning the project, please contact me on 233 501295329 (Ghana) or Haldis Haukanes, +47 55589259 (Norway).

The study has been approved by the Norwegian Centre for Research Data and subject to the data protection laws of the University of Bergen. It has also been notified to the ethical review committee of the College of Health Sciences, University of Ghana.

You have the right to request access to, deletion/correction/limitation of one's personal data, as well as the right to data portability.

You also have the right to send a complaint to the Data Protection Officer for the data controller or The Norwegian Data Protection Authority.

You can contact the Data Protection Officer on phone number: +47 55 58 21 17.

I have received information about the project and am willing to participate

1. I agree to participate in this interview without audio recording.

(Signed by participant, date)

2. I agree to participate in this interview with audio recording.

(Signed by participant, date)

Request for participation in research project:

Transforming gender relations? Men's involvement in care for their partners and households at the time of pregnancy in rural and urban Ghana. A qualitative study

PI: Gloria Abena Ampim

PhD Candidate, University of Bergen (UiB)

Information letter for health workers

Background and Purpose

The purpose of this project is to understand how men and women think about fatherhood, fathers experiences and practices during pregnancy and after the birth of the child and also their experiences of programs which are designed to support them to cope with pregnancy and parenting. It is a PhD project at the University of Bergen, Norway and it is also funded by the University. Topics to be covered will include, how men and women understand fatherhood, some of the social expectations of fathers in Ghana, how men support their partners during pregnancy, men's experience of health services for ante-natal care and post-natal care, their experiences of pregnancy schools or other programmes they are involved in and health service providers' experiences of working with men.

You have been selected to participate in this study because you are a nurse-midwife/Community Health Nurse in this health facility/community and in regular contact with expectant parents.

We will have an interview for approximately 45-60 minutes during which I will seek understanding on your experience working with fathers at the facility and in the community some of the social expectations of fathers in Ghana, how men support their partners during pregnancy and some challenges of involving men in maternal and infant health care in Ghana. During the interview, I will take notes of your answers and also audio record ONLY if you permit me to.

Your name and personal details will not be recorded. The information shared in this interview will remain confidential and only myself and supervisors will have access to it. The data will also be anonymized and in publications information will not be linked to any participant.
The project is scheduled for completion by the end of 2022. Throughout the project, the data will be anonymised and after completion, the anonymous version of the data will be stored by the project team. You will not incur any cost by participating in this study. However, you will be reimbursed your cost of travel if the interview takes place outside your home.

Voluntary participation

It is voluntary to participate in the project, and you can at any time choose to withdraw your consent without stating any reason. If you decide to withdraw, you will not be punished by the facility administration; neither will it affect the relationship with your clients. If you would like to participate, we can schedule an appointment now. If you have any questions concerning the project, please contact me on 233 501295329 (Ghana) or Haldis Haukanes, +47 55589259 (Norway).

The study has been approved by the Norwegian Centre for Research Data and subject to the data protection laws of the University of Bergen. It has also been notified to the ethical review

committee of the College of Health Sciences, University of Ghana.

You have the right to request access to, deletion/correction/limitation of one's personal data, as well as the right to data portability.

You also have the right to send a complaint to the Data Protection Officer for the data controller or The Norwegian Data Protection Authority.

You can contact the Data Protection Officer on phone number: +47 55 58 21 17

I have received information about the project and am willing to participate

1. I agree to participate in this interview without audio recording.

(Signed by participant, date)

2. I agree to participate in this interview with audio recording.

(Signed by participant, date)

Appendix III: Semistructured interview guide for expectant fathers

Research title: Transforming gender relations? Men's involvement in care for their partners and households at the time of pregnancy in rural and urban Ghana. A qualitative study

Introduction of the study and the interviewer

Section A: Background information

1. Can you please describe your residential situation?
    - Can you please describe your job situation?
2. How did you find out that your partner is pregnant? Were you expecting it?
    - What were your initial reactions?
    - Did you and your partner seek additional knowledge about pregnancy? How?
3. What do you do to support your partner?
    - What did you do to support your partner with yesterday?
    - What is your day like on a working day?
    - What is your day like on a Saturday?
    - What is your day like on a Sunday?

Section B: Fathering roles and practices during pregnancy

4. How important is it for you to become a father?
5. Has the expectation of a baby changed your role as a husband? How?
6. What are the characteristics of a good father?
    - Which of these characteristics are most important?
7. What were your experiences of fatherhood when growing up?

- Has this experience influenced you in your support for your partner? How?
- Would you say your role as an expectant father now is different from fathers' role when you were growing up? [Probe for possible reasons]
- Have these differences also changed what it is to be a man? If yes, how?
- Would you say your role as an expectant father is different from the role of other fathers around you? If yes, how?
- Would you say your role as a father in an urban/rural area is different from the role of a father in rural/urban area? If yes, how?

8. Are there limitations to what a man can do to support his partner during pregnancy? [Probe for examples and reasons]

Section C: Role of family

9. How does your family support you and your partner?
10. How does your wife's family support you and your partner?

Section D: Men's experiences of health service delivery and providers

11. When was the first time you attended antenatal care services? What was your experience the first time?
12. What have your subsequent experiences with antenatal care services been?
13. How do service providers engage men? Do they have any special messages for you?
14. What do service providers expect from men?
15. What are the kinds of interactions between men and service providers?

Wrapping up

16. What are your expectations when your child finally arrives?

Thank you very much for participating in this interview. Are there additional issues that you find important but that I did not ask about?

Thank you once again. It has been very educative speaking to you. I have learnt so much. As I indicated at the beginning I will be pleased if you agree to be interviewed again after the birth of your child. However, remember that you are not obliged to agree. The questions will be similar to what we have discussed today but will be more related to your experience with the care and parenting of your baby. Would you like to be interviewed again after the birth of your child?

Thank you very much for your time and for participating.

Appendix IV: Focus group discussion guide

Research Title: Transforming gender relations? Men's involvement in care for their partners and households at the time of pregnancy in rural and urban Ghana. A qualitative study.

Introduction of the study and facilitator

Section A: Expectations of fathers during pregnancy

Vignette

Dora and Charles have been married for 5 years and live in Accra (Afram Plains). Dora is four months pregnant and Charles has taken up the responsibility for the housework. He usually wakes up early in the morning to sweep, clean, cooks and wash. What Charles does not know is that his landlord has been observing him for some time. One day, he overhead his landlord telling his friend that Charles is silly because he sweeps and cleans while Dora is resting and washes her clothes, including underwear. However, this did not stop Charles from performing any house chores. One day, the landlord and his friend approached Charles and asked him to stop performing housework because it is embarrassing. They threatened that if he does not stop, they will report him to his mother.

Questions for discussion

1. What should Charles do?
2. Is the landlord and his friend's concern appropriate? Why or why not?
    - Will other people (in the community) also think like them?
3. How will Charles' family members react when they hear that he does housework?

Section B: Fathering roles

4. What are men's roles during pregnancy and after birth? [if not already mentioned. If mentioned, go over the list and probe for more.]
5. What new things are fathers doing now that they did not do previously for their partners and children?

Section C: Support for fathers and the new parents

6. What kinds of support do family members and neighbours give couples during pregnancy and after birth?
7. How involved are men in this community in antenatal and postnatal clinics?

Section D: Importance of fatherhood

8. When does fatherhood begin?
9. How important is it to become a father?
10. How does becoming a father heighten a man's status in the society?
11. What are the characteristics of a good father?
12. Which of these characteristics mentioned are most important?

Wrapping up

13. If you had the chance to meet with the District Director of Health to talk about male involvement, what would be your suggestion about how men should support during pregnancy and after childbirth? Why?

[Summary by facilitator] Is this a good summary of the discussion?

Have we missed anything else we should have discussed?

Thank you very much for your participation.

Appendix V: Semistructured interviews with health workers

Research title: Transforming gender relations? Men's involvement in care for their partners and households at the time of pregnancy in rural and urban Ghana. A qualitative study

Introduction of the study and the interviewer

Questions

1. Can you please tell me a little about yourself, like how long you have been working here and your roles at this health facility?
2. What are your views on involving men in antenatal services/delivery/postnatal care?
3. What are some of the ways men are encouraged to participate in maternal and infant health care? [Probe]
    - How are fathers involved by service providers during pregnancy?
    - How often are women encouraged to bring their partners to the clinic?
    - How are men encouraged to attend antenatal clinics?
    - What about pregnancy schools? How are participants informed and recruited?
4. How are men engaged by health service providers at the health facility? [Probe for specific examples]
5. Are men more likely to participate in ANC than PNC or vice versa? Why?
6. For the men who participate, what strategies do you use to sustain their participation in these clinics?
7. What are some of the benefits that fathers will receive from their involvement?
8. What are some factors that facilitate fathers' involvement?
    - Which of these factors are related to expectant fathers and mothers?

- Which of these factors are related to the health facility or health system?
- Which of these factors are related to extended family members?
- Which of these factors are related to the community?

9. What are some factors that hinder fathers' involvement?
    - What are some specific things that expectant fathers and expectant mothers do that can hinder fathers' involvement?
    - What are some factors related to the health facility or health system that can hinder fathers' involvement?
    - What are some of the barriers you think there are in this local area/community in involving fathers?
10. How do you engage fathers who are absent from antenatal and postnatal appointments?
11. What kind of support do health service providers need to engage men with fathers?
12. Do you consider gender norms when engaging with fathers at the clinic? How?
    - Would you say masculine norms influence male involvement? How?
    - How important is it for Ghanaian men to become fathers?
    - Are there different expectations of fathers than there were before? What are some of these? Would you say these fatherhood norms influence male involvement?

Wrapping up

Thank you very much for participating in this interview.

[Give a brief summary of the topics discussed]

Are there additional issues that you find important but I did not ask?

Appendix VI: Semistructured interviews with new fathers

Research title: Transforming gender relations? Men's involvement in care for their partners and households at the time of pregnancy in rural and urban Ghana. A qualitative study

Introduction, greetings and congratulations on becoming a father

Section A: Background information

Go over the background information from the previous interview to outline changes that have occurred since then, for example changes in:

- Residential situation
- Employment situation

Section B: Fathering roles and practices – Revisit some of the initial motivation to have a child and to become a father

1. I would like to start from the beginning. Tell me about your motivation to have a child?
    - How important was it for you to become a father?
    - How did you experience the pregnancy process?
    - What were some of the memorable times?
    - How did the expectation of having a baby affect your relationship with your wife?
    - What were some of the things you did to support her?
    - Were there limitations to what you could do?
2. Tell me about the day your baby arrived?
    - How were you feeling generally that day?
    - Labour experience

- Participate in the delivery?
- How were you engaged by service providers?

3. Tell me about your son/daughter.
    - How has her/his birth changed your world?
    - What kind of relationship do you see emerging between the two of you?
    - What are some of the memories you are creating with your child?
    - How has the birth of your child affected your relationship with your wife?
    - How do you care for your child? [Probe for physical, emotional, and financial]
    - What are some of the things you do now as a husband that you did not do before?
    - Are there limitations to what you do for your child?
4. Tell me about your work? How do you balance work and care for your child?

Section C: Fathers' childhood experiences

5. Tell me about your childhood, where you grew up, how many siblings you had, etc.

- What was your relationship with your father like?
- Which aspects of your childhood experience do you want your child to experience?
- Which aspects of your childhood experience do you not want your child to experience?
- What are the characteristics of a good father?
- Which of these characteristics are most important for you towards your child?

Section D: Role of family

6. Tell me about the role your family has played in the care for your child.
    - What role did your family play in your decision to father a child?
    - How did your families support you and your partner during the pregnancy? [Probe for both sides]

- How does your family support you to care for the child? [Probe for both sides]

Section E: Men's experiences of health services

7. What were your experiences of antenatal care services since our last interview?
    - How were your experiences of antenatal care services towards the ends of the pregnancy? Where there any differences in your experience since the last time we met?
    - How did you feel being there? How did health workers engage you?
    - What were the attitude of others (men and women) towards you at the clinic?
8. Do you participate in postnatal services?
    - What are your experiences?
    - How do you feel being there?
    - How do health workers engage you?
    - What are the attitude of others (men and women) towards you at the clinic?
9. What are the differences in experience of antenatal and postnatal?

Wrapping up

Thank you very much for participating in this interview once again. Are there additional issues that you find important but I did not ask?

Appendix VII: Sample of thematic analysis for the three peer-reviewed articles

Article I				
Data Extract	**Codes**	**Sub-category**	**Category**	**Theme**
When he gets a child as far as you have been able to impregnate a woman and she has given birth, you automatically become a father. If someone asks a child the where about of his father, he would go and call the man who brought him to the world. Therefore, once he has given birth to a child, he is called a father.	Biological fatherhood	When does fatherhood begin	Conceptions of fatherhood	Becoming and being a father
Those who do not care are not supposed to be called fathers. They do not deserve that title because if you really love your wife and children, you would not let them pass through hard times though you know you can help.	Fatherhood is a role			
I think fatherhood starts when you start taking care of your woman. Because if you can take care of your woman, it means you can take care of your children too.	Fatherhood before biological children			
A good father is the one who takes care of the needs of his family, the clothes of his children, their food, shelter and all other needs of the family.	Providing food, shelter and clothes for the family	Characteristics of a good father		
Even before he gets someone pregnant, he has plans of making a family so he makes sure the woman does not have problems because of him.	Planning for the future			
However, the main responsibility of the man is to give the woman money for upkeep. When they go to the hospital, the cost is also the responsibility of the man.	Men are expected to provide money for care	Additional roles of fathers during pregnancy	Male responsibilities during pregnancy	
Another thing we do is that we support them in household chores during that period. Some of the men carry firewood from the farm and then leave them on the way for their wives to bring home.	Intensify the performance of housework			

Article II				
Data Extract	**Codes**	**Sub-category**	**Category**	**Theme**
So as for the consulting room, I always make sure I am there with her because I want to see if everything is in place. Therefore, if there's any lab test, I would like to know its result and what to do about it.	Involvement in private consultation	Varying involvement of men in ANC	Motivation for involvement in the care for partners' pregnancy	Men experience the maternity clinic as 'escorts'
Like I was told by the Korle Bu doctor to pack pillows for her to sit on. We realised that it worked because I learned from what the doctor taught me. I do not know anything about pregnancy, but this experience has taught me a lot that I will be a better father when my wife gets pregnant again in the future.	Learning to care for a pregnant woman	Men's agenda at ANC		
I would not like to sit in the midst of the ladies. There should be a special place for the men who come here with their partners. Therefore, if they have a place for the visitors, it would be very good.	Men stay away from the clinic	Discomfort in a space largely occupied by women	Men's experiences of antenatal care services	
We check how many males who accompany their wives to come. So one thing we try to do to motivate the men is that, when you come with your wife, you are the first to be served. We use that to motivate them. It made the women use that as a tool to invite their husbands. Last time we were discussing how there should be some event to celebrate the men, so that others will be motivated to get involved.	Women accompanied by men are allowed to jump the queue	Health workers' strategies and challenges to engaging male attendees	Structural constraints of health workers in including men in ANC services	

Article III				
Data Extract	**Codes**	**Sub-category**	**Category**	**Theme**
They would leave all the work for the men to do. [Laughing] Some are lazy. Since they know that the men would do it, they would find ways and means to use sickness as an excuse to leave the work for the men to do. As we speak for ourselves, we should speak for the men too. Because some are very helpful, they make sure their wives are well taken care of.	Some pregnant women are lazy	Negative female attitudes during pregnancy	Motivation for involvement in the care for partners' pregnancy	Shifts in household gender relations during the time of pregnancy
It gives you happiness, knowing that you are supporting your wife and at the end having a good child out of the whole process. If you do that together, even at the child's young age, he would know that there is some kind of unity in the family.	Men become emotionally satisfied when they support expectant mothers	Affection, love and understanding between couples		
Yes. If there is love and understanding, even when his friends complain, he will rather warn them to stay off his marriage. He will even advise his friends to do the same.	Love and understanding			
At times, some people refer to them as fools because they see them helping their wives with common pounding of fufu. When the men go through that, they become discouraged then stop supporting the women in the manner they wish.	Societal perception of men who do housework	Male attitudes towards care for partners		
You know when a woman is pregnant, she becomes a little weaker than her usual strength so I do my very best to support her at home.	Condition of the woman	Helping hand	Men's responsibilities during pregnancy	
Even when she is washing, the man should at least give a helping hand by putting the things on the line to dry in order to have a peaceful home.	Strive for a peaceful home			

Doctoral Theses at The Faculty of Psychology, University of Bergen

1980	Allen, Hugh M., Dr. philos.	Parent-offspring interactions in willow grouse (Lagopus L. Lagopus).
1981	Myhrer, Trond, Dr. philos.	Behavioral Studies after selective disruption of hippocampal inputs in albino rats.
1982	Svebak, Sven, Dr. philos.	The significance of motivation for task-induced tonic physiological changes.
1983	Myhre, Grete, Dr. philos.	The Biopsychology of behavior in captive Willow ptarmigan.
	Eide, Rolf, Dr. philos.	PSYCHOSOCIAL FACTORS AND INDICES OF HEALTH RISKS. The relationship of psychosocial conditions to subjective complaints, arterial blood pressure, serum cholesterol, serum triglycerides and urinary catecholamines in middle aged populations in Western Norway.
	Værnes, Ragnar J., Dr. philos.	Neuropsychological effects of diving.
1984	Kolstad, Arnulf, Dr. philos.	Til diskusjonen om sammenhengen mellom sosiale forhold og psykiske strukturer. En epidemiologisk undersøkelse blant barn og unge.
	Løberg, Tor, Dr. philos.	Neuropsychological assessment in alcohol dependence.
1985	Hellesnes, Tore, Dr. philos.	Læring og problemløsning. En studie av den perseptuelle analysens betydning for verbal læring.
	Håland, Wenche, Dr. philos.	Psykoterapi: relasjon, utviklingsprosess og effekt.
1986	Hagtvet, Knut A., Dr. philos.	The construct of test anxiety: Conceptual and methodological issues.
	Jellestad, Finn K., Dr. philos.	Effects of neuron specific amygdala lesions on fear-motivated behavior in rats.
1987	Aarø, Leif E., Dr. philos.	Health behaviour and sosioeconomic Status. A survey among the adult population in Norway.
	Underlid, Kjell, Dr. philos.	Arbeidsløyse i psykososialt perspektiv.
	Laberg, Jon C., Dr. philos.	Expectancy and classical conditioning in alcoholics' craving.
	Vollmer, Fred, Dr. philos.	Essays on explanation in psychology.
	Ellertsen, Bjørn, Dr. philos.	Migraine and tension headache: Psychophysiology, personality and therapy.
1988	Kaufmann, Astrid, Dr. philos.	Antisosial atferd hos ungdom. En studie av psykologiske determinanter.

	Mykletun, Reidar J., Dr. philos.	Teacher stress: personality, work-load and health.
	Havik, Odd E., Dr. philos.	After the myocardial infarction: A medical and psychological study with special emphasis on perceived illness.
1989	Bråten, Stein, Dr. philos.	Menneskedyaden. En teoretisk tese om sinnets dialogiske natur med informasjons- og utviklingspsykologiske implikasjoner sammenholdt med utvalgte spedbarnsstudier.
	Wold, Bente, Dr. psychol.	Lifestyles and physical activity. A theoretical and empirical analysis of socialization among children and adolescents.
1990	Flaten, Magne A., Dr. psychol.	The role of habituation and learning in reflex modification.
1991	Alsaker, Françoise D., Dr. philos.	Global negative self-evaluations in early adolescence.
	Kraft, Pål, Dr. philos.	AIDS prevention in Norway. Empirical studies on diffusion of knowledge, public opinion, and sexual behaviour.
	Endresen, Inger M., Dr. philos.	Psychoimmuniological stress markers in working life.
	Faleide, Asbjørn O., Dr. philos.	Asthma and allergy in childhood. Psychosocial and psychotherapeutic problems.
1992	Dalen, Knut, Dr. philos.	Hemispheric asymmetry and the Dual-Task Paradigm: An experimental approach.
	Bø, Inge B., Dr. philos.	Ungdoms sosiale økologi. En undersøkelse av 14-16 åringers sosiale nettverk.
	Nivison, Mary E., Dr. philos.	The relationship between noise as an experimental and environmental stressor, physiological changes and psychological factors.
	Torgersen, Anne M., Dr. philos.	Genetic and environmental influence on temperamental behaviour. A longitudinal study of twins from infancy to adolescence.
1993	Larsen, Svein, Dr. philos.	Cultural background and problem drinking.
	Nordhus, Inger Hilde, Dr. philos.	Family caregiving. A community psychological study with special emphasis on clinical interventions.
	Thuen, Frode, Dr. psychol.	Accident-related behaviour among children and young adolescents: Prediction and prevention.
	Solheim, Ragnar, Dr. philos.	Spesifikke lærevansker. Diskrepanskriteriet anvendt i seleksjonsmetodikk.
	Johnsen, Bjørn Helge, Dr. psychol.	Brain assymetry and facial emotional expressions: Conditioning experiments.
1994	Tønnessen, Finn E., Dr. philos.	The etiology of Dyslexia.
	Kvale, Gerd, Dr. psychol.	Psychological factors in anticipatory nausea and vomiting in cancer chemotherapy.
	Asbjørnsen, Arve E., Dr. psychol.	Structural and dynamic factors in dichotic listening: An interactional model.

	Bru, Edvin, Dr. philos.	The role of psychological factors in neck, shoulder and low back pain among female hospitale staff.
	Braathen, Eli T., Dr. psychol.	Prediction of exellence and discontinuation in different types of sport: The significance of motivation and EMG.
	Johannessen, Birte F., Dr. philos.	Det flytende kjønnet. Om lederskap, politikk og identitet.
1995	Sam, David L., Dr. psychol.	Acculturation of young immigrants in Norway: A psychological and socio-cultural adaptation.
	Bjaalid, Inger-Kristin, Dr. philos.	Component processes in word recognition.
	Martinsen, Øyvind, Dr. philos.	Cognitive style and insight.
	Nordby, Helge, Dr. philos.	Processing of auditory deviant events: Mismatch negativity of event-related brain potentials.
	Raaheim, Arild, Dr. philos.	Health perception and health behaviour, theoretical considerations, empirical studies, and practical implications.
	Seltzer, Wencke J., Dr. philos.	Studies of Psychocultural Approach to Families in Therapy.
	Brun, Wibecke, Dr. philos.	Subjective conceptions of uncertainty and risk.
	Aas, Henrik N., Dr. psychol.	Alcohol expectancies and socialization: Adolescents learning to drink.
	Bjørkly, Stål, Dr. psychol.	Diagnosis and prediction of intra-institutional aggressive behaviour in psychotic patients
1996	Anderssen, Norman, Dr. psychol.	Physical activity of young people in a health perspective: Stability, change and social influences.
	Sandal, Gro Mjeldheim, Dr. psychol.	Coping in extreme environments: The role of personality.
	Strumse, Einar, Dr. philos.	The psychology of aesthetics: explaining visual preferences for agrarian landscapes in Western Norway.
	Hestad, Knut, Dr. philos.	Neuropsychological deficits in HIV-1 infection.
	Lugoe, L.Wycliffe, Dr. philos.	Prediction of Tanzanian students' HIV risk and preventive behaviours
	Sandvik, B. Gunnhild, Dr. philos.	Fra distriktsjordmor til institusjonsjordmor. Fremveksten av en profesjon og en profesjonsutdanning
	Lie, Gro Therese, Dr. psychol.	The disease that dares not speak its name: Studies on factors of importance for coping with HIV/AIDS in Northern Tanzania
	Øygard, Lisbet, Dr. philos.	Health behaviors among young adults. A psychological and sociological approach
	Stormark, Kjell Morten, Dr. psychol.	Emotional modulation of selective attention: Experimental and clinical evidence.
	Einarsen, Ståle, Dr. psychol.	Bullying and harassment at work: epidemiological and psychosocial aspects.

1997	Knivsberg, Ann-Mari, Dr. philos.	Behavioural abnormalities and childhood psychopathology: Urinary peptide patterns as a potential tool in diagnosis and remediation.
	Eide, Arne H., Dr. philos.	Adolescent drug use in Zimbabwe. Cultural orientation in a global-local perspective and use of psychoactive substances among secondary school students.
	Sørensen, Marit, Dr. philos.	The psychology of initiating and maintaining exercise and diet behaviour.
	Skjæveland, Oddvar, Dr. psychol.	Relationships between spatial-physical neighborhood attributes and social relations among neighbors.
	Zewdie, Teka, Dr. philos.	Mother-child relational patterns in Ethiopia. Issues of developmental theories and intervention programs.
	Wilhelmsen, Britt Unni, Dr. philos.	Development and evaluation of two educational programmes designed to prevent alcohol use among adolescents.
	Manger, Terje, Dr. philos.	Gender differences in mathematical achievement among Norwegian elementary school students.
1998 V	Lindstrøm, Torill Christine, Dr. philos.	«Good Grief»: Adapting to Bereavement.
	Skogstad, Anders, Dr. philos.	Effects of leadership behaviour on job satisfaction, health and efficiency.
	Haldorsen, Ellen M. Håland, Dr. psychol.	Return to work in low back pain patients.
	Besemer, Susan P., Dr. philos.	Creative Product Analysis: The Search for a Valid Model for Understanding Creativity in Products.
H	Winje, Dagfinn, Dr. psychol.	Psychological adjustment after severe trauma. A longitudinal study of adults' and children's posttraumatic reactions and coping after the bus accident in Måbødalen, Norway 1988.
	Vosburg, Suzanne K., Dr. philos.	The effects of mood on creative problem solving.
	Eriksen, Hege R., Dr. philos.	Stress and coping: Does it really matter for subjective health complaints?
	Jakobsen, Reidar, Dr. psychol.	Empiriske studier av kunnskap og holdninger om hiv/aids og den normative seksuelle utvikling i ungdomsårene.
1999 V	Mikkelsen, Aslaug, Dr. philos.	Effects of learning opportunities and learning climate on occupational health.
	Samdal, Oddrun, Dr. philos.	The school environment as a risk or resource for students' health-related behaviours and subjective well-being.
	Friestad, Christine, Dr. philos.	Social psychological approaches to smoking.
	Ekeland, Tor-Johan, Dr. philos.	Meining som medisin. Ein analyse av placebofenomenet og implikasjoner for terapi og terapeutiske teoriar.
H	Saban, Sara, Dr. psychol.	Brain Asymmetry and Attention: Classical Conditioning Experiments.

	Carlsten, Carl Thomas, Dr. philos.	God lesing – God læring. En aksjonsrettet studie av undervisning i fagtekstlesing.
	Dundas, Ingrid, Dr. psychol.	Functional and dysfunctional closeness. Family interaction and children's adjustment.
	Engen, Liv, Dr. philos.	Kartlegging av leseferdighet på småskoletrinnet og vurdering av faktorer som kan være av betydning for optimal leseutvikling.
2000 V	Hovland, Ole Johan, Dr. philos.	Transforming a self-preserving "alarm" reaction into a self-defeating emotional response: Toward an integrative approach to anxiety as a human phenomenon.
	Lillejord, Sølvi, Dr. philos.	Handlingsrasjonalitet og spesialundervisning. En analyse av aktørperspektiver.
	Sandell, Ove, Dr. philos.	Den varme kunnskapen.
	Oftedal, Marit Petersen, Dr. philos.	Diagnostisering av ordavkodingsvansker: En prosessanalytisk tilnærmingsmåte.
H	Sandbak, Tone, Dr. psychol.	Alcohol consumption and preference in the rat: The significance of individual differences and relationships to stress pathology
	Eid, Jarle, Dr. psychol.	Early predictors of PTSD symptom reporting; The significance of contextual and individual factors.
2001 V	Skinstad, Anne Helene, Dr. philos.	Substance dependence and borderline personality disorders.
	Binder, Per-Einar, Dr. psychol.	Individet og den meningsbærende andre. En teoretisk undersøkelse av de mellommenneskelige forutsetningene for psykisk liv og utvikling med utgangspunkt i Donald Winnicotts teori.
	Roald, Ingvild K., Dr. philos.	Building of concepts. A study of Physics concepts of Norwegian deaf students.
H	Fekadu, Zelalem W., Dr. philos.	Predicting contraceptive use and intention among a sample of adolescent girls. An application of the theory of planned behaviour in Ethiopian context.
	Melesse, Fantu, Dr. philos.	The more intelligent and sensitive child (MISC) mediational intervention in an Ethiopian context: An evaluation study.
	Råheim, Målfrid, Dr. philos.	Kvinners kroppserfaring og livssammenheng. En fenomenologisk – hermeneutisk studie av friske kvinner og kvinner med kroniske muskelsmerter.
	Engelsen, Birthe Kari, Dr. psychol.	Measurement of the eating problem construct.
	Lau, Bjørn, Dr. philos.	Weight and eating concerns in adolescence.
2002 V	Ihlebæk, Camilla, Dr. philos.	Epidemiological studies of subjective health complaints.
	Rosén, Gunnar O. R., Dr. philos.	The phantom limb experience. Models for understanding and treatment of pain with hypnosis.

	Høines, Marit Johnsen, Dr. philos.	Fleksible språkrom. Matematikklæring som tekstutvikling.
	Anthun, Roald Andor, Dr. philos.	School psychology service quality. Consumer appraisal, quality dimensions, and collaborative improvement potential
	Pallesen, Ståle, Dr. psychol.	Insomnia in the elderly. Epidemiology, psychological characteristics and treatment.
	Midthassel, Unni Vere, Dr. philos.	Teacher involvement in school development activity. A study of teachers in Norwegian compulsory schools
	Kallestad, Jan Helge, Dr. philos.	Teachers, schools and implementation of the Olweus Bullying Prevention Program.
H	Ofte, Sonja Helgesen, Dr. psychol.	Right-left discrimination in adults and children.
	Netland, Marit, Dr. psychol.	Exposure to political violence. The need to estimate our estimations.
	Diseth, Åge, Dr. psychol.	Approaches to learning: Validity and prediction of academic performance.
	Bjuland, Raymond, Dr. philos.	Problem solving in geometry. Reasoning processes of student teachers working in small groups: A dialogical approach.
2003 V	Arefjord, Kjersti, Dr. psychol.	After the myocardial infarction – the wives' view. Short- and long-term adjustment in wives of myocardial infarction patients.
	Ingjaldsson, Jón Þorvaldur, Dr. psychol.	Unconscious Processes and Vagal Activity in Alcohol Dependency.
	Holden, Børge, Dr. philos.	Følger av atferdsanalytiske forklaringer for atferdsanalysens tilnærming til utforming av behandling.
	Holsen, Ingrid, Dr. philos.	Depressed mood from adolescence to 'emerging adulthood'. Course and longitudinal influences of body image and parent-adolescent relationship.
	Hammar, Åsa Karin, Dr. psychol.	Major depression and cognitive dysfunction- An experimental study of the cognitive effort hypothesis.
	Sprugevica, Ieva, Dr. philos.	The impact of enabling skills on early reading acquisition.
	Gabrielsen, Egil, Dr. philos.	LESE FOR LIVET. Lesekompetansen i den norske voksenbefolkningen sett i lys av visjonen om en enhetsskole.
H	Hansen, Anita Lill, Dr. psychol.	The influence of heart rate variability in the regulation of attentional and memory processes.
	Dyregrov, Kari, Dr. philos.	The loss of child by suicide, SIDS, and accidents: Consequences, needs and provisions of help.
2004 V	Torsheim, Torbjørn, Dr. psychol.	Student role strain and subjective health complaints: Individual, contextual, and longitudinal perspectives.
	Haugland, Bente Storm Mowatt Dr. psychol.	Parental alcohol abuse. Family functioning and child adjustment.

	Milde, Anne Marita, Dr. psychol.	Ulcerative colitis and the role of stress. Animal studies of psychobiological factors in relationship to experimentally induced colitis.
	Stornes, Tor, Dr. philos.	Socio-moral behaviour in sport. An investigation of perceptions of sportspersonship in handball related to important factors of socio-moral influence.
	Mæhle, Magne, Dr. philos.	Re-inventing the child in family therapy: An investigation of the relevance and applicability of theory and research in child development for family therapy involving children.
	Kobbeltvedt, Therese, Dr. psychol.	Risk and feelings: A field approach.
2004 H	Thomsen, Tormod, Dr. psychol.	Localization of attention in the brain.
	Løberg, Else-Marie, Dr. psychol.	Functional laterality and attention modulation in schizophrenia: Effects of clinical variables.
	Kyrkjebø, Jane Mikkelsen, Dr. philos.	Learning to improve: Integrating continuous quality improvement learning into nursing education.
	Laumann, Karin, Dr. psychol.	Restorative and stress-reducing effects of natural environments: Experiencal, behavioural and cardiovascular indices.
	Holgersen, Helge, PhD	Mellom oss - Essay i relasjonell psykoanalyse.
2005 V	Hetland, Hilde, Dr. psychol.	Leading to the extraordinary? Antecedents and outcomes of transformational leadership.
	Iversen, Anette Christine, Dr. philos.	Social differences in health behaviour: the motivational role of perceived control and coping.
2005 H	Mathisen, Gro Ellen, PhD	Climates for creativity and innovation: Definitions, measurement, predictors and consequences.
	Sævi, Tone, Dr. philos.	Seeing disability pedagogically – The lived experience of disability in the pedagogical encounter.
	Wiium, Nora, PhD	Intrapersonal factors, family and school norms: combined and interactive influence on adolescent smoking behaviour.
	Kanagaratnam, Pushpa, PhD	Subjective and objective correlates of Posttraumatic Stress in immigrants/refugees exposed to political violence.
	Larsen, Torill M. B. , PhD	Evaluating principals` and teachers` implementation of Second Step. A case study of four Norwegian primary schools.
	Bancila, Delia, PhD	Psychosocial stress and distress among Romanian adolescents and adults.
2006 V	Hillestad, Torgeir Martin, Dr. philos.	Normalitet og avvik. Forutsetninger for et objektivt psykopatologisk avviksbegrep. En psykologisk, sosial, erkjennelsesteoretisk og teorihistorisk framstilling.
	Nordanger, Dag Øystein, Dr. psychol.	Psychosocial discourses and responses to political violence in post-war Tigray, Ethiopia.

	Rimol, Lars Morten, PhD	Behavioral and fMRI studies of auditory laterality and speech sound processing.
	Krumsvik, Rune Johan, Dr. philos.	ICT in the school. ICT-initiated school development in lower secondary school.
	Norman, Elisabeth, Dr. psychol.	Gut feelings and unconscious thought: An exploration of fringe consiousness in implicit cognition.
	Israel, K Pravin, Dr. psychol.	Parent involvement in the mental health care of children and adolescents. Emperical studies from clinical care setting.
	Glasø, Lars, PhD	Affects and emotional regulation in leader-subordinate relationships.
	Knutsen, Ketil, Dr. philos.	HISTORIER UNGDOM LEVER – En studie av hvordan ungdommer bruker historie for å gjøre livet meningsfullt.
	Matthiesen, Stig Berge, PhD	Bullying at work. Antecedents and outcomes.
2006 H	Gramstad, Arne, PhD	Neuropsychological assessment of cognitive and emotional functioning in patients with epilepsy.
	Bendixen, Mons, PhD	Antisocial behaviour in early adolescence: Methodological and substantive issues.
	Mrumbi, Khalifa Maulid, PhD	Parental illness and loss to HIV/AIDS as experienced by AIDS orphans aged between 12-17 years from Temeke District, Dar es Salaam, Tanzania: A study of the children's psychosocial health and coping responses.
	Hetland, Jørn, Dr. psychol.	The nature of subjective health complaints in adolescence: Dimensionality, stability, and psychosocial predictors
	Kakoko, Deodatus Conatus Vitalis, PhD	Voluntary HIV counselling and testing service uptake among primary school teachers in Mwanza, Tanzania: assessment of socio-demographic, psychosocial and socio-cognitive aspects
	Mykletun, Arnstein, Dr. psychol.	Mortality and work-related disability as long-term consequences of anxiety and depression: Historical cohort designs based on the HUNT-2 study
	Sivertsen, Børge, PhD	Insomnia in older adults. Consequences, assessment and treatment.
2007 V	Singhammer, John, Dr. philos.	Social conditions from before birth to early adulthood – the influence on health and health behaviour
	Janvin, Carmen Ani Cristea, PhD	Cognitive impairment in patients with Parkinson's disease: profiles and implications for prognosis
	Braarud, Hanne Cecilie, Dr.psychol.	Infant regulation of distress: A longitudinal study of transactions between mothers and infants
	Tveito, Torill Helene, PhD	Sick Leave and Subjective Health Complaints
	Magnussen, Liv Heide, PhD	Returning disability pensioners with back pain to work

	Thuen, Elin Marie, Dr.philos.	Learning environment, students' coping styles and emotional and behavioural problems. A study of Norwegian secondary school students.
	Solberg, Ole Asbjørn, PhD	Peacekeeping warriors – A longitudinal study of Norwegian peacekeepers in Kosovo
2007 H	Søreide, Gunn Elisabeth, Dr.philos.	Narrative construction of teacher identity
	Svensen, Erling, PhD	WORK & HEALTH. Cognitive Activation Theory of Stress applied in an organisational setting.
	Øverland, Simon Nygaard, PhD	Mental health and impairment in disability benefits. Studies applying linkages between health surveys and administrative registries.
	Eichele, Tom, PhD	Electrophysiological and Hemodynamic Correlates of Expectancy in Target Processing
	Børhaug, Kjetil, Dr.philos.	Oppseding til demokrati. Ein studie av politisk oppseding i norsk skule.
	Eikeland, Thorleif, Dr.philos.	Om å vokse opp på barnehjem og på sykehus. En undersøkelse av barnehjemsbarns opplevelser på barnehjem sammenholdt med sanatoriebarns beskrivelse av langvarige sykehusopphold – og et forsøk på forklaring.
	Wadel, Carl Cato, Dr.philos.	Medarbeidersamhandling og medarbeiderledelse i en lagbasert organisasjon
	Vinje, Hege Forbech, PhD	Thriving despite adversity: Job engagement and self-care among community nurses
	Noort, Maurits van den, PhD	Working memory capacity and foreign language acquisition
2008 V	Breivik, Kyrre, Dr.psychol.	The Adjustment of Children and Adolescents in Different Post-Divorce Family Structures. A Norwegian Study of Risks and Mechanisms.
	Johnsen, Grethe E., PhD	Memory impairment in patients with posttraumatic stress disorder
	Sætrevik, Bjørn, PhD	Cognitive Control in Auditory Processing
	Carvalhosa, Susana Fonseca, PhD	Prevention of bullying in schools: an ecological model
2008 H	Brønnick, Kolbjørn Selvåg	Attentional dysfunction in dementia associated with Parkinson's disease.
	Posserud, Maj-Britt Rocio	Epidemiology of autism spectrum disorders
	Haug, Ellen	Multilevel correlates of physical activity in the school setting
	Skjerve, Arvid	Assessing mild dementia – a study of brief cognitive tests.

	Kjønniksen, Lise	The association between adolescent experiences in physical activity and leisure time physical activity in adulthood: a ten year longitudinal study
	Gundersen, Hilde	The effects of alcohol and expectancy on brain function
	Omvik, Siri	Insomnia – a night and day problem
2009 V	Molde, Helge	Pathological gambling: prevalence, mechanisms and treatment outcome.
	Foss, Else	Den omsorgsfulle væremåte. En studie av voksnes væremåte i forhold til barn i barnehagen.
	Westrheim, Kariane	Education in a Political Context: A study of Konwledge Processes and Learning Sites in the PKK.
	Wehling, Eike	Cognitive and olfactory changes in aging
	Wangberg, Silje C.	Internet based interventions to support health behaviours: The role of self-efficacy.
	Nielsen, Morten B.	Methodological issues in research on workplace bullying. Operationalisations, measurements and samples.
	Sandu, Anca Larisa	MRI measures of brain volume and cortical complexity in clinical groups and during development.
	Guribye, Eugene	Refugees and mental health interventions
	Sørensen, Lin	Emotional problems in inattentive children – effects on cognitive control functions.
	Tjomsland, Hege E.	Health promotion with teachers. Evaluation of the Norwegian Network of Health Promoting Schools: Quantitative and qualitative analyses of predisposing, reinforcing and enabling conditions related to teacher participation and program sustainability.
	Helleve, Ingrid	Productive interactions in ICT supported communities of learners
2009 H	Skorpen, Aina Øye, Christine	Dagliglivet i en psykiatrisk institusjon: En analyse av miljøterapeutiske praksiser
	Andreassen, Cecilie Schou	WORKAHOLISM – Antecedents and Outcomes
	Stang, Ingun	Being in the same boat: An empowerment intervention in breast cancer self-help groups
	Sequeira, Sarah Dorothee Dos Santos	The effects of background noise on asymmetrical speech perception
	Kleiven, Jo, dr.philos.	The Lillehammer scales: Measuring common motives for vacation and leisure behavior
	Jónsdóttir, Guðrún	Dubito ergo sum? Ni jenter møter naturfaglig kunnskap.
	Hove, Oddbjørn	Mental health disorders in adults with intellectual disabilities - Methods of assessment and prevalence of mental health disorders and problem behaviour
	Wageningen, Heidi Karin van	The role of glutamate on brain function

	Bjørkvik, Jofrid	God nok? Selvaktelse og interpersonlig fungering hos pasienter innen psykisk helsevern: Forholdet til diagnoser, symptomer og behandlingsutbytte
	Andersson, Martin	A study of attention control in children and elderly using a forced-attention dichotic listening paradigm
	Almås, Aslaug Grov	Teachers in the Digital Network Society: Visions and Realities. A study of teachers' experiences with the use of ICT in teaching and learning.
	Ulvik, Marit	Lærerutdanning som danning? Tre stemmer i diskusjonen
2010 V	Skår, Randi	Læringsprosesser i sykepleieres profesjonsutøvelse. En studie av sykepleieres læringserfaringer.
	Roald, Knut	Kvalitetsvurdering som organisasjonslæring mellom skole og skoleeigar
	Lunde, Linn-Heidi	Chronic pain in older adults. Consequences, assessment and treatment.
	Danielsen, Anne Grete	Perceived psychosocial support, students' self-reported academic initiative and perceived life satisfaction
	Hysing, Mari	Mental health in children with chronic illness
	Olsen, Olav Kjellevold	Are good leaders moral leaders? The relationship between effective military operational leadership and morals
	Riese, Hanne	Friendship and learning. Entrepreneurship education through mini-enterprises.
	Holthe, Asle	Evaluating the implementation of the Norwegian guidelines for healthy school meals: A case study involving three secondary schools
H	Hauge, Lars Johan	Environmental antecedents of workplace bullying: A multi-design approach
	Bjørkelo, Brita	Whistleblowing at work: Antecedents and consequences
	Reme, Silje Endresen	Common Complaints – Common Cure? Psychiatric comorbidity and predictors of treatment outcome in low back pain and irritable bowel syndrome
	Helland, Wenche Andersen	Communication difficulties in children identified with psychiatric problems
	Beneventi, Harald	Neuronal correlates of working memory in dyslexia
	Thygesen, Elin	Subjective health and coping in care-dependent old persons living at home
	Aanes, Mette Marthinussen	Poor social relationships as a threat to belongingness needs. Interpersonal stress and subjective health complaints: Mediating and moderating factors.
	Anker, Morten Gustav	Client directed outcome informed couple therapy

	Bull, Torill	Combining employment and child care: The subjective well-being of single women in Scandinavia and in Southern Europe
	Viig, Nina Grieg	Tilrettelegging for læreres deltakelse i helsefremmende arbeid. En kvalitativ og kvantitativ analyse av sammenhengen mellom organisatoriske forhold og læreres deltakelse i utvikling og implementering av Europeisk Nettverk av Helsefremmende Skoler i Norge
	Wolff, Katharina	To know or not to know? Attitudes towards receiving genetic information among patients and the general public.
	Ogden, Terje, dr.philos.	Familiebasert behandling av alvorlige atferdsproblemer blant barn og ungdom. Evaluering og implementering av evidensbaserte behandlingsprogrammer i Norge.
	Solberg, Mona Elin	Self-reported bullying and victimisation at school: Prevalence, overlap and psychosocial adjustment.
2011 V	Bye, Hege Høivik	Self-presentation in job interviews. Individual and cultural differences in applicant self-presentation during job interviews and hiring managers' evaluation
	Notelaers, Guy	Workplace bullying. A risk control perspective.
	Moltu, Christian	Being a therapist in difficult therapeutic impasses. A hermeneutic phenomenological analysis of skilled psychotherapists' experiences, needs, and strategies in difficult therapies ending well.
	Myrseth, Helga	Pathological Gambling - Treatment and Personality Factors
	Schanche, Elisabeth	From self-criticism to self-compassion. An empirical investigation of hypothesized change prosesses in the Affect Phobia Treatment Model of short-term dynamic psychotherapy for patients with Cluster C personality disorders.
	Våpenstad, Eystein Victor, dr.philos.	Det tempererte nærvær. En teoretisk undersøkelse av psykoterapautens subjektivitet i psykoanalyse og psykoanalytisk psykoterapi.
	Haukebø, Kristin	Cognitive, behavioral and neural correlates of dental and intra-oral injection phobia. Results from one treatment and one fMRI study of randomized, controlled design.
	Harris, Anette	Adaptation and health in extreme and isolated environments. From 78°N to 75°S.
	Bjørknes, Ragnhild	Parent Management Training-Oregon Model: intervention effects on maternal practice and child behavior in ethnic minority families
	Mamen, Asgeir	Aspects of using physical training in patients with substance dependence and additional mental distress
	Espevik, Roar	Expert teams: Do shared mental models of team members make a difference
	Haara, Frode Olav	Unveiling teachers' reasons for choosing practical activities in mathematics teaching

2011 H	Hauge, Hans Abraham	How can employee empowerment be made conducive to both employee health and organisation performance? An empirical investigation of a tailor-made approach to organisation learning in a municipal public service organisation.
	Melkevik, Ole Rogstad	Screen-based sedentary behaviours: pastimes for the poor, inactive and overweight? A cross-national survey of children and adolescents in 39 countries.
	Vøllestad, Jon	Mindfulness-based treatment for anxiety disorders. A quantitative review of the evidence, results from a randomized controlled trial, and a qualitative exploration of patient experiences.
	Tolo, Astrid	Hvordan blir lærerkompetanse konstruert? En kvalitativ studie av PPU-studenters kunnskapsutvikling.
	Saus, Evelyn-Rose	Training effectiveness: Situation awareness training in simulators
	Nordgreen, Tine	Internet-based self-help for social anxiety disorder and panic disorder. Factors associated with effect and use of self-help.
	Munkvold, Linda Helen	Oppositional Defiant Disorder: Informant discrepancies, gender differences, co-occuring mental health problems and neurocognitive function.
	Christiansen, Øivin	Når barn plasseres utenfor hjemmet: beslutninger, forløp og relasjoner. Under barnevernets (ved)tak.
	Brunborg, Geir Scott	Conditionability and Reinforcement Sensitivity in Gambling Behaviour
	Hystad, Sigurd William	Measuring Psychological Resiliency: Validation of an Adapted Norwegian Hardiness Scale
2012 V	Roness, Dag	Hvorfor bli lærer? Motivasjon for utdanning og utøving.
	Fjermestad, Krister Westlye	The therapeutic alliance in cognitive behavioural therapy for youth anxiety disorders
	Jenssen, Eirik Sørnes	Tilpasset opplæring i norsk skole: politikeres, skoleledereres og læreres handlingsvalg
	Saksvik-Lehouillier, Ingvild	Shift work tolerance and adaptation to shift work among offshore workers and nurses
	Johansen, Venke Frederike	Når det intime blir offentlig. Om kvinners åpenhet om brystkreft og om markedsføring av brystkreftsaken.
	Herheim, Rune	Pupils collaborating in pairs at a computer in mathematics learning: investigating verbal communication patterns and qualities
	Vie, Tina Løkke	Cognitive appraisal, emotions and subjective health complaints among victims of workplace bullying: A stress-theoretical approach
	Jones, Lise Øen	Effects of reading skills, spelling skills and accompanying efficacy beliefs on participation in education. A study in Norwegian prisons.

2012 H	Danielsen, Yngvild Sørebø	Childhood obesity – characteristics and treatment. Psychological perspectives.
	Horverak, Jøri Gytre	Sense or sensibility in hiring processes. Interviewee and interviewer characteristics as antecedents of immigrant applicants' employment probabilities. An experimental approach.
	Jøsendal, Ola	Development and evaluation of BE smokeFREE, a school-based smoking prevention program
	Osnes, Berge	Temporal and Posterior Frontal Involvement in Auditory Speech Perception
	Drageset, Sigrunn	Psychological distress, coping and social support in the diagnostic and preoperative phase of breast cancer
	Aasland, Merethe Schanke	Destructive leadership: Conceptualization, measurement, prevalence and outcomes
	Bakibinga, Pauline	The experience of job engagement and self-care among Ugandan nurses and midwives
	Skogen, Jens Christoffer	Foetal and early origins of old age health. Linkage between birth records and the old age cohort of the Hordaland Health Study (HUSK)
	Leversen, Ingrid	Adolescents' leisure activity participation and their life satisfaction: The role of demographic characteristics and psychological processes
	Hanss, Daniel	Explaining sustainable consumption: Findings from cross-sectional and intervention approaches
	Rød, Per Arne	Barn i klem mellom foreldrekonflikter og samfunnsmessig beskyttelse
2013 V	Mentzoni, Rune Aune	Structural Characteristics in Gambling
	Knudsen, Ann Kristin	Long-term sickness absence and disability pension award as consequences of common mental disorders. Epidemiological studies using a population-based health survey and official ill health benefit registries.
	Strand, Mari	Emotional information processing in recurrent MDD
	Veseth, Marius	Recovery in bipolar disorder. A reflexive-collaborative exploration of the lived experiences of healing and growth when battling a severe mental illness
	Mæland, Silje	Sick leave for patients with severe subjective health complaints. Challenges in general practice.
	Mjaaland, Thera	At the frontiers of change? Women and girls' pursuit of education in north-western Tigray, Ethiopia
	Odéen, Magnus	Coping at work. The role of knowledge and coping expectancies in health and sick leave.
	Hynninen, Kia Minna Johanna	Anxiety, depression and sleep disturbance in chronic obstructive pulmonary disease (COPD). Associations, prevalence and effect of psychological treatment.
	Flo, Elisabeth	Sleep and health in shift working nurses

	Aasen, Elin Margrethe	From paternalism to patient participation? The older patients undergoing hemodialysis, their next of kin and the nurses: a discursive perspective on perception of patient participation in dialysis units
	Ekornås, Belinda	Emotional and Behavioural Problems in Children: Self-perception, peer relationships, and motor abilities
	Corbin, J. Hope	North-South Partnerships for Health: Key Factors for Partnership Success from the Perspective of the KIWAKKUKI
	Birkeland, Marianne Skogbrott	Development of global self-esteem: The transition from adolescence to adulthood
2013 H	Gianella-Malca, Camila	Challenges in Implementing the Colombian Constitutional Court's Health-Care System Ruling of 2008
	Hovland, Anders	Panic disorder – Treatment outcomes and psychophysiological concomitants
	Mortensen, Øystein	The transition to parenthood – Couple relationships put to the test
	Årdal, Guro	Major Depressive Disorder – a Ten Year Follow-up Study. Inhibition, Information Processing and Health Related Quality of Life
	Johansen, Rino Bandlitz	The impact of military identity on performance in the Norwegian armed forces
	Bøe, Tormod	Socioeconomic Status and Mental Health in Children and Adolescents
2014 V	Nordmo, Ivar	Gjennom nåløyet – studenters læringserfaringer i psykologutdanningen
	Dovran, Anders	Childhood Trauma and Mental Health Problems in Adult Life
	Hegelstad, Wenche ten Velden	Early Detection and Intervention in Psychosis: A Long-Term Perspective
	Urheim, Ragnar	Forståelse av pasientaggresjon og forklaringer på nedgang i voldsrate ved Regional sikkerhetsavdeling, Sandviken sykehus
	Kinn, Liv Grethe	Round-Trips to Work. Qualitative studies of how persons with severe mental illness experience work integration.
	Rød, Anne Marie Kinn	Consequences of social defeat stress for behaviour and sleep. Short-term and long-term assessments in rats.
	Nygård, Merethe	Schizophrenia – Cognitive Function, Brain Abnormalities, and Cannabis Use
	Tjora, Tore	Smoking from adolescence through adulthood: the role of family, friends, depression and socioeconomic status. Predictors of smoking from age 13 to 30 in the "The Norwegian Longitudinal Health Behaviour Study" (NLHB)
	Vangsnes, Vigdis	The Dramaturgy and Didactics of Computer Gaming. A Study of a Medium in the Educational Context of Kindergartens.

	Nordahl, Kristin Berg	Early Father-Child Interaction in a Father-Friendly Context: Gender Differences, Child Outcomes, and Protective Factors related to Fathers' Parenting Behaviors with One-year-olds
2014 H	Sandvik, Asle Makoto	Psychopathy – the heterogenety of the construct
	Skotheim, Siv	Maternal emotional distress and early mother-infant interaction: Psychological, social and nutritional contributions
	Halleland, Helene Barone	Executive Functioning in adult Attention Deficit Hyperactivity Disorder (ADHD). From basic mechanisms to functional outcome.
	Halvorsen, Kirsti Vindal	Partnerskap i lærerutdanning, sett fra et økologisk perspektiv
	Solbue, Vibeke	Dialogen som visker ut kategorier. En studie av hvilke erfaringer innvandrerungdommer og norskfødte med innvandrerforeldre har med videregående skole. Hva forteller ungdommenes erfaringer om videregående skoles håndtering av etniske ulikheter?
	Kvalevaag, Anne Lise	Fathers' mental health and child development. The predictive value of fathers' psychological distress during pregnancy for the social, emotional and behavioural development of their children
	Sandal, Ann Karin	Ungdom og utdanningsval. Om elevar sine opplevingar av val og overgangsprosessar.
	Haug, Thomas	Predictors and moderators of treatment outcome from high- and low-intensity cognitive behavioral therapy for anxiety disorders. Association between patient and process factors, and the outcome from guided self-help, stepped care, and face-to-face cognitive behavioral therapy.
	Sjølie, Hege	Experiences of Members of a Crisis Resolution Home Treatment Team. Personal history, professional role and emotional support in a CRHT team.
	Falkenberg, Liv Eggset	Neuronal underpinnings of healthy and dysfunctional cognitive control
	Mrdalj, Jelena	The early life condition. Importance for sleep, circadian rhythmicity, behaviour and response to later life challenges
	Hesjedal, Elisabeth	Tverrprofesjonelt samarbeid mellom skule og barnevern: Kva kan støtte utsette barn og unge?
2015 V	Hauken, May Aasebø	«*The cancer treatment was only half the work!»* A Mixed-Method Study of Rehabilitation among Young Adult Cancer Survivors
	Ryland, Hilde Katrin	Social functioning and mental health in children: the influence of chronic illness and intellectual function
	Rønsen, Anne Kristin	Vurdering som profesjonskompetanse. Refleksjonsbasert utvikling av læreres kompetanse i formativ vurdering

	Hoff, Helge Andreas	Thinking about Symptoms of Psychopathy in Norway: Content Validation of the Comprehensive Assessment of Psychopathic Personality (CAPP) Model in a Norwegian Setting
	Schmid, Marit Therese	Executive Functioning in recurrent- and first episode Major Depressive Disorder. Longitudinal studies
	Sand, Liv	Body Image Distortion and Eating Disturbances in Children and Adolescents
	Matanda, Dennis Juma	Child physical growth and care practices in Kenya: Evidence from Demographic and Health Surveys
	Amugsi, Dickson Abanimi	Child care practices, resources for care, and nutritional outcomes in Ghana: Findings from Demographic and Health Surveys
	Jakobsen, Hilde	The good beating: Social norms supporting men's partner violence in Tanzania
	Sagoe, Dominic	Nonmedical anabolic-androgenic steroid use: Prevalence, attitudes, and social perception
	Eide, Helene Marie Kjærgård	Narrating the relationship between leadership and learning outcomes. A study of public narratives in the Norwegian educational sector.
2015 H	Wubs, Annegreet Gera	Intimate partner violence among adolescents in South Africa and Tanzania
	Hjelmervik, Helene Susanne	Sex and sex-hormonal effects on brain organization of fronto-parietal networks
	Dahl, Berit Misund	The meaning of professional identity in public health nursing
	Røykenes, Kari	Testangst hos sykepleierstudenter: «Alternativ behandling»
	Bless, Josef Johann	The smartphone as a research tool in psychology. Assessment of language lateralization and training of auditory attention.
	Løvvik, Camilla Margrethe Sigvaldsen	Common mental disorders and work participation – the role of return-to-work expectations
	Lehmann, Stine	Mental Disorders in Foster Children: A Study of Prevalence, Comorbidity, and Risk Factors
	Knapstad, Marit	Psychological factors in long-term sickness absence: the role of shame and social support. Epidemiological studies based on the Health Assets Project.
2016 V	Kvestad, Ingrid	Biological risks and neurodevelopment in young North Indian children
	Sælør, Knut Tore	Hinderløyper, halmstrå og hengende snører. En kvalitativ studie av håp innenfor psykisk helse- og rusfeltet.
	Mellingen, Sonja	Alkoholbruk, partilfredshet og samlivsstatus. Før, inn i, og etter svangerskapet – korrelater eller konsekvenser?
	Thun, Eirunn	Shift work: negative consequences and protective factors

	Hilt, Line Torbjørnsen	The borderlands of educational inclusion. Analyses of inclusion and exclusion processes for minority language students
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