

Expressions of Masculinity and Femininity in Husbands' Care of Wives with Cancer in Accra

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Abstract: This article explores the care that husbands in Accra, Ghana, provide for wives who have been diagnosed with cancer. Making use of an inductive, qualitative approach, the study analyzes observations of and in-depth ethnographic interviews conducted with five married female cancer patients and their husbands over a ten-month period. The results suggest a strong association among husbands' care, wives' responses to husbands' care, and cultural ideals of femininity and masculinity. The findings suggest that husbands' selective and often limited gender-based investments in unpaid care work make their sick wives exceedingly vulnerable in a context in which care for the terminally ill takes place predominately in familial settings.

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Résumé: Cet article explore les soins fournis par les maris aux femmes qui ont été diagnostiquées avec le cancer, à Accra, au Ghana. À l'aide d'une approche inductive, qualitative, l'étude analyse les observations extraites d'entretiens ethnographiques approfondis menés auprès de cinq femmes mariées, atteintes de cancer, et leurs maris, durant une période de dix mois. Les résultats suggèrent une forte association entre le soin des maris, les réponses des femmes aux soins des maris, et les idéaux culturels de féminité et de masculinité. Les résultats suggèrent que les investissements des maris dans la réalisation de soin non rémunérés qui sont fondés sur le genre et sont sélectifs et souvent limités, rendent les épouses malades très vulnérables puisqu'elles se trouvent dans un contexte dans lequel les soins pour les malades en phase terminale a lieu principalement dans les milieux familiaux.

Keywords: Marriage; spousal care; cancer; femininity; masculinity; Ghana

Introduction

As gloomy epidemiological forecasts about the increasing incidence of chronic diseases in the global South are being realized (Steward et al. 2014; Jemal et al. 2011; Ferlay et al. 2010), families and communities have become increasingly burdened with the care and support of the sick. This burden is particularly profound in sub-Saharan Africa, where formal health care systems are weak. This article considers a number of questions: how have sociocultural and economic changes, particularly in urban cosmopolitan settings, upset family norms, values, and arrangements in care for people with chronic illnesses? How are husbands able to care for wives diagnosed with chronic illnesses in a culture in which caretaking functions typically are performed by women? And how do Ghanaian constructions of masculinity and femininity obstruct or enhance husbands' care for wives diagnosed with cancer?

Care for cancer patients includes all the forms of support and personal assistance that help a patient live a comfortable life. Such care involves some unique challenges. Caregivers need to provide not only practical assistance but also intense emotional support, particularly to reassure patients that their diagnosis is not an immediate death sentence. Cancer treatments (particularly chemotherapy and radiotherapy) are highly toxic and have severely uncomfortable and even painful side effects including nausea, vomiting, fatigue, weakness, and reduced immunity (Miller-Keane & O'Toole 1992). Families have to collaborate with health practitioners for the effective management of these conditions (Thompson 1976).

In industrialized economies people diagnosed with cancer and their family caregivers can benefit from financial compensation as well as institutional support from clinical psychologists, social welfare systems, visiting nurse services, day care services, and other support programs (Given et al. 2012).¹ At the terminal stage, palliative care, usually in hospices, is provided to manage symptoms by reducing pain, enhancing patient comfort, slowing

disease progression where possible, and in some cases providing spiritual and existential comfort for the dying (Malin et al. 2006; Ferris et al. 2009). Such services are not available in most of Africa (Atobrah 2013; Bessa et al. 2012; Ohaeri et al. 2011; Nuhu et al. 2013; Livingston 2013).² In addition, when families do engage professionals or other paid workers to care for the seriously ill, they are frequently stigmatized, as this “outsourcing” is seen as a sign of family dysfunction or downright wickedness (Agyei-Mensah & de Graft Aikins 2010; Atobrah 2009). The family is expected to be, and frequently is, the main source of care. And the main providers, what's more, are typically women. Although historical evidence exists of men's material contributions to care of kin throughout Africa, it is women and their matrikin who are mainly responsible for providing everyday care, especially for the sick and aged (Atobrah 2013; Apt 2002; Robertson 1984; Oppong 2006). Historical accounts show that the contributions of female slaves, servants, and nonrelatives in the care of the seriously sick were important, and that the prevailing socioeconomic and cultural conditions of the 1930s and 1940s under colonial rule made it convenient for care to be feminized (Atobrah 2013).

Yet today many of the conditions that supported the feminization of care are disappearing. Family systems are undergoing transformations characterized by urbanization, including increasing distances between residences, long(er) years spent in education and training, and employment outside the home—leading to a weakening of lineage bonds of support and care and of the so-called safety net (Ocholla Ayayo 2000; Oppong 2004, 2006; Nukunya 2003). Female enrollment in basic and secondary schools has increased because of national programs to enhance and increase girls' education and changing attitudes to formal education (Adoo-Adiku 2012), and traditional fostering practices that provided a steady stream of younger relatives in the home have declined (Afrifa 2010). As marriages have become more nuclearized, obligations toward kinship groups have weakened, and the traditional caring role of the matrikin in many African societies is fast eroding (Oppong 2004). Together, these circumstances create the need for an increased participation of males in family caregiving. In this article we explore the husbands' care of wives who have been diagnosed with cancer. Is a paradigm shift observable in the context of prevailing femininities and masculinities?

Reflections on Class and Status in the Changing Sociocultural Context of Accra

Accra is one of the fastest growing cities in Africa (Doan & Oduro 2012). It can be described as cosmopolitan and modern, with a mixed economy and a melting pot of different ethnicities and nationalities. In 1960 the urban population of Greater Accra was 72.6 percent of the total, but by 2010 it had grown to 90.5 percent, an increase of 18 percent in 50 years (GSS 2013).

More than half of households in Accra fall within the highest wealth quintile in the country, and less than 5 percent of households fall within the lowest wealth quintile. In the Accra metropolis, household size averages 3.5 people, and about 66.4 percent of the population lives in compound houses with shared user facilities, characterized by shifts from traditional sex-segregated households to co-residence of spouses (GSS 2013). Marriage remains important, and the 2010 Population and Housing Census indicates that 44 percent of women and 42 percent of men above age twelve were married (GSS 2013). Although the prevalence of polygyny has declined in Ghana, anecdotal evidence suggests that pseudo-polygyny is alive and well (Adomako Ampofo & Okyerefo 2014).³

Over the past two decades many corporate organizations have taken up residence in Accra, opening up spaces for women's formal-sector employment and opportunities to earn better incomes (Adomako Ampofo & Anyidoho 2015). Nonetheless, female subordination in Greater Accra, if measured by abuse, is high. The 2007 Ghana Demographic and Health Survey (GDHS) indicated that 40.1 percent of female respondents in Greater Accra believe husbands are justified if they beat their wives for reasons such as failure to prepare meals or refusing sex (GSS 2008).

While this paper focuses on husbands' care for their chronically ill wives, a comment on the possible intersection of gender with other variables such as class and status is useful. Drawing on the Yoruba, Oyewumi (1997) suggests that status via seniority is a significant social marker in African societies, though she has been criticized for essentializing Yoruba (and African) societies and failing to recognize that men everywhere are more likely to be accorded senior status than women (see Apusigah 2008). Nonetheless, in the years immediately preceding and following independence, generational positions within the family and class associations—by birth and family name, or attendance at certain schools—were very important. In addition, as is true elsewhere, working-class solidarity has been undermined by the increasing demands on women's labor both in the formal sector and the domestic realm (Oppong 2004). The structural reforms and liberalization of Ghana's economy in the 1980s and beyond further rendered notions of class as somewhat nebulous, reducing it principally to differentiations according to wealth. One's so-called (economic) class is based on what one can afford to do and be, and therefore it does not have an exclusive culture or lifestyle of its own. Remittances and gifts from family members abroad also facilitate upward mobility among disparate social groups, including many recent migrants to the cities with little or no education, and the obvious outward trappings of material goods that people associate with economic and class status—such as smart phones and fashionable clothing—are available to many. In the last couple of decades political allegiance and patronage, international sportsmanship, and entertainment have catapulted some people from near-poverty to extreme wealth within a few years, and class politics have assumed new dimensions that frequently pit the poor and "middle class" against a growing, obviously wealthy political class.⁴

To further complicate notions of class, Ghana's changing economic fortunes find some individuals moving from one class to another based on circumstances. Class, therefore, has become quite a fluid concept, and more and more evidence suggests an almost uniform social system in which, for women, gender itself is the most salient characteristic (Yeboah et al. 2014). These observations align with Ortner's (1991) suggestion that "class, as a fundamental category, is often deflected or dispersed into categories like gender, race or ethnicity, which are more easily reconciled with the demands of a liberal ideology and its solution to social problems" (cited in Yang 2010:552).

Performances of Femininity and Masculinity in Ghanaian Society

Care for the chronically ill in Ghana is delivered through deliberate planning and strategizing, guided by sociocultural norms, values, and sanctions (Atobrah 2013). Typically, the roles played by different individuals in this care vary, but in terms of performance and abstention they are influenced strongly by ideals of masculinity and femininity.⁵

Scholars have long debated questions about the status of women in Ghana. Ghanaian women, in general, are noted for their resilience, autonomy, industry, and acquisition of personal property, wealth, and resources (Adomako Ampofo et al. 2004; Manuh 1988; Oppong 2006), and some emphasize the high statuses of women and complementarity of gender roles even prior to colonialism (Aidoo 1985; Arhin 1983). Others argue that even if one acknowledges these rights and privileges, the status of women historically has been lower than that of men (Adomako Ampofo et al. 2004; Apusiga 2008; Manuh 1998; Prah 1996; Sarpong 1977). Much of this asymmetry remains today, even as norms and practices have changed and as numerous feminist and gender-based civil society organizations (CSOs) and nongovernmental organizations (NGOs), since the 1970s, have pushed for greater gender equality (see Adomako Ampofo 2007; Tripp 2009). For example, assumptions that a husband's payment of bridewealth gives him uxorial rights over his wife's reproductive and domestic services retain some salience (Frost & Dodoo 2010) even though many brides now contribute to their own "bridewealth" packages. Polygyny also remains common, and while this marriage arrangement creates opportunities for autonomy for some women through the sharing of reproductive work (Aidoo 1985), arguments about its patriarchal underpinnings (e.g., Manuh 1998) are still relevant. Reproductive work remains a female preserve, and even in polygynous situations the reproductive roles of women remain unchallenged. In addition, while in the past women had the support of female matrikin in the domestic sphere, in today's urban economy, with women increasingly employed in the formal sector or outside the home, this help is less available and working women themselves have to effectively work a double shift or rely on paid, as opposed to familial, domestic help (Tsikata 2009).

Despite these social and economic changes, popular culture homogenizes the characteristics of an ideal woman as a natural, committed, faithful, and effective nurturer of the species who embraces domesticity, cooks for her family (preferably fresh food daily) and sees to the efficient and seamless management of her home. Her reproductive role is valorized to the extent that it is considered a “biological aberration for a woman not to care about children” (Oduyoye 2000:60). Wives are expected to be hard working and resourceful on behalf of their lineages and their husbands, to be sober, quiet, harmless, self-controlled, respectful, and submissive, and to defer to their husbands and other men (see Nukunya 2003; Adomako Ampofo & Boateng 2007). Indeed, women who do not conform to these ideal notions of womanhood become easy targets for witchcraft accusations (Badoo 2005, Oduyoye 200).

In this valorization of domesticity, the reality that many women work outside the home is ignored, as is the fact that many men, far from embodying the coexisting myth of the male provider, are unemployed. In many families women are not only a co-provider, but also often the major provider. In this context contemporary Ghanaian society has, to some extent, not *invented* the model of the idyllic woman but rather *reinvented* it. This ideal woman—who is not only a loving and faithful wife and mother, but also a “supplementary” provider who is submissive to her husband, morally upright, modestly dressed, and demure—would be virtually unrecognizable to the adroit and entrepreneurial women of a few generations ago, whose allegiance to lineage members sometimes even trumped submission to husbands.

In popular music, for example, women who make good wives are presented in contrast to the ubiquitous bad girl who is overtly sexual, greedy, and unfaithful (see Adomako Ampofo & Asiedu 2012). Radio and television advertising presents stereotypical images of a happy wife or girlfriend whose partner works hard to provide for her needs as well as modern comforts. Societal fears of being overrun by rebellious women who neglect husbands and children are palpable. This was clear, for example, even in the discussions surrounding the 2007 Domestic Violence Act in which the Minister for Women and Children’s Affairs cautioned that the legislation—which her ministry was supposed to be championing—could lead to the breakup of families (Adomako Ampofo 2008). A similar ambivalence can be found in the discourses of contemporary Christian religious movements and the doctrines of leading male church leaders which hearken “to idyllic notions of Euro-domesticity that could be inimical to women’s autonomy” (Adomako Ampofo & Okyerefo 2014:165) even as they address some of the abuses of contemporary gender politics such as spousal abuse and parental neglect.

Of course, context, history, and experience are important factors not only in the cultural creation of the ideal female in Ghanaian society but in the construction of masculinity as well. A growing body of work analyzes the nature of dominant or ruling “masculinities” even as it pays attention to the diverse forms that exist and problematizes any notion of unambiguous

male hegemony. A number of studies carried out among youths and young men show that two areas of accomplishment and ambition are emphasized among this demographic group—success in the economic and social spheres and sexual potency (see Ratale 2011; Morrell et al. 2012). Other studies focusing on culturally appropriate gender roles show how boys are exempted from performing domestic tasks, including care of the sick, because these are considered female responsibilities (Adomako Ampofo & Boateng 2007). Some boys may “help” their mothers with domestic tasks, but most are emphatic that household work such as cooking and caring for the sick is women’s work, and that in the future they could see themselves performing such tasks only to “help” a sick or absent wife. Ruling African masculinity is still seen as both honorable and prestigious, as exemplified by what has been referred to as the “Big Man” in Nigeria and the *ɔpanyin* in Ghana (Miescher 2007).⁶ This concept refers to a “real” man as a senior member of the community with the ability to provide resources, protection, security, defense, and safety for his family, particularly the female members (Lindsay 2005; Shefer et al. 2007) but also other dependants in the kin group and community (Adomako Ampofo & Boateng 2007; Adomako Ampofo et al. 2009; Meischer 2007). Among most ethnic groups in Ghana a man’s inability to provide for his family is sufficient grounds for divorce (Robertson 1984; Clark 2010). An *ɔpanyin* is also expected to have the ability to ward off evil from afflicting his family, and “real” men are therefore expected to exhibit (masculine) virtues of bravery, boldness, power, and strength and the ability to endure physical and emotional pain, distress, agony, or grief. It is considered unmasculine for a man to exhibit emotions publicly, and the phrase “*bema en su*” (men don’t cry) is frequently invoked in traumatic situations (Adomako Ampofo & Boateng 2007). True masculinity is also associated with male virility, sexual prowess, fertility (particularly having sons), and even having multiple sexual partners. In some cases such pressures involving sexual performance have been shown to lead to violent or risky behaviors (Adomako Ampofo et al. 2009; Inhorn 2002; Nyanzi et al. 2005).

Of course, as a caveat to the above it should be acknowledged that alternative masculinities and femininities also exist in Ghana, including sexual relationships between men (Banks 2012) and between women (Dankwa 2011). And, just as we see particular groups of males and females deliberately reversing or (re)negotiating the normative gender practices, or even creating alternative identities for themselves, studies among some young men show increasing support for more egalitarian relationships with women. However, what remains significant is that men seem more amenable to “de-gendering” (Agadjanian 2002) and compromising masculinity ideals that pertain to work and survival than to domestic configurations. In this article we are interested in exploring the extent to which standards of femininity and masculinity mediate wives’ expectations of their husbands when they fall ill, and husbands’ care for their sick wives. Specifically, we investigate the particular conflicts and tensions that arise when men do (or do not) assist in caring for wives diagnosed with cancer. We argue that in this situation,

as in other marital contexts, gendered notions of femininity and masculinity define expectations regarding appropriate roles and behaviors, spousal rights, duties, and responsibilities, all of which shape the expectations for and delivery of care.

Conceptualizing Masculinities and Care for the Chronically Sick

Studies carried out in Europe and North America have shown that the number of men involved in primary caregiving for sick relatives has increased tremendously in the past few decades, with men making up about a third of caregivers in some settings (Calasanti & King 2007; Russell 2001, 2007a; Hayes et al. 2001; Thompson 2002; Ribeiro et al. 2007). While variables such as age cohort, stage in the life course, ethnicity and race, and economic status are usually recognized as playing important roles in men's care practices, analyses of men's care of their sick wives have yielded two basic perspectives, which are mostly contradictory.

The first perspective suggests that the work of male caregivers is largely ineffective and inconsequential, and that their care is of lower quality than the care provided by women. Studies have found that men provide care for only short periods of time (Allen 1994; Stoller 1990), that they relinquish their responsibilities when the going becomes tough (Parks & Pilisuk 1991), and that they take an instrumental approach in providing care, mostly concerning themselves with logistical needs such as transportation or managing financial matters and rarely getting involved in the arduous daily tasks of practical caregiving (Montgomery & Kamo 1989; Pruchno & Resch 1989). According to this perspective male caregivers tend to be impatient, unempathic, and not entirely dependable; they do not spend enough time with patients and are unable to discern and meet their emotional needs (Stoller 1990; Kaye & Applegate 1994).

The second perspective suggests that men are not only able caregivers (Thompson 1997; Russell 2001, 2007a), but also that they can be uniquely effective in the caregiving role because they are able to call upon their management and work skills of organizing, planning, and control. According to this perspective, their somewhat "professional" attitude toward caregiving shields them from the emotional agony and burnout usually associated with this role (Calasanti & King 2007) and they are able, for example, to manage their own lives and activities more effectively than women caregivers (Hayes & Zimmerman 2009).

These two perspectives, however, are based largely on studies of spousal care for elderly women with cognitive impairment conditions, particularly Alzheimer's disease or dementia. Studies of middle-aged husbands of wives with breast cancer suggest a less variable picture. These studies indicate that the men experience significant levels of distress from observing the disfigurement and fatigue caused by cancer treatment and surgery, as well as from the inhibition of sexual intimacy and the personal and household disruptions that result (Zahlis & Shands 1991; Northouse et al. 1998),

and that a significant proportion of husbands even express higher levels of distress than their wives (Langer et al 2003; Northouse & Swain 1987). Observed effects of wives' cancer diagnoses on husbands include sleep disruptions, eating disorders, hair loss, increased signs of aging, an inability to work, and at times an exacerbation of preexisting marital problems (Wellisch et al. 1978; Zalis & Shands 1991). Zalis and Shands (1991) observe further that husbands often feel guilty about the inadequacy of the support they provide for their wives.

Many of these researchers point out the problem of using feminine standards of care when assessing men's caregiving (Calasanti & King 2007). Thompson (2002) suggests that there is a kind "double jeopardy" involved in these evaluations—if men care just as women do, they could be termed deviant and effeminate, while if they care in their own ways they are considered ineffective and unappreciated. According to at least one study (Calasanti & King 2007), these preconceived gender boundaries are less significant in the case of older husbands in Western societies who have already experienced reduced sexual desire or capabilities. Nevertheless, the fact remains that while men's care responses to their wives' illnesses are context specific and based on the particular illness under consideration (Hayes & Zimmerman 2009), they are also largely socially constructed around gender norms,

Methodology

The data in this article were derived from a larger ethnographic study of twenty-four Ghanains diagnosed with serious diseases—including cancer, stroke, chronic diabetes, and chronic renal disease—members of their families, and networks of caregivers (Atobrah 2009). Fieldwork was conducted over a ten-month period in 2007, and contact with patients and their caregivers was maintained until all the patients had died. This article focuses on five cases of women diagnosed with cancer—one with ovarian cancer, two with breast cancer, one with cancer of the endometrium, and one with both breast and ovarian cancer. The women were recruited for the study from the Center for Radiotherapy at the Korle Bu Teaching Hospital in Accra with the consent of the medical-officer-in-charge and with the help of nurses and other health personnel. In all cases, entry and exit interviews were conducted with key personnel at the center for verification and clarity on relevant medical issues. The observation of ethical guidelines was key to the research process, and ethical clearance was obtained from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research of the University of Ghana.

The article is based primarily on in-depth conversation-style interviews with five terminally ill wives, their husbands, and other kin—a total of fifteen individuals (see table). A comment on the sample size is in order here. The use of small samples in in-depth qualitative studies has been shown to enable the researcher to "be immersed in the research field,

to establish continuing, fruitful relationships with respondents and through theoretical contemplation to address the research problem in depth” (Crouch & McKenzie 2006:483). Because the study required examining intimate aspects of the lives of terminally ill wives and their families, and because wives tended to be secretive, and in some cases even “superstitious,” about their cancer diagnosis, much time had to be spent on building trust and confidence. The only practical approach, therefore, was to concentrate on a small sample, arguably at the expense of generalizability. Nevertheless, we believe that the data provide meaningful insights for wider applicability.

In each case at least eight conversations were carried out focused on the husbands’ participation in caring for their wives. Three main areas were emphasized: (1) material care, including the provision, or facilitating the provision, of the wife’s financial needs; (2) practical care, including routine tasks such as assistance with feeding, toileting, bathing, and cleaning; cooking, laundry, running errands, and other routine household tasks; and accompanying the patient on hospital visits; and (3) emotional care, including assuaging the fears, anxieties, and depression of the patients and providing spiritual support through prayer and religious exhortations.

All of the interviews and observations were carried out by the first author. She also helped patients and their family members with transportation, provided fruits and vegetables, helped to physically lift patients, assisted with hospital bookings, and sometimes even made small financial contributions. Ghanaian society remains deeply communal, and it would have been considered culturally unacceptable for anyone, even the ethnographer-observer, to visit a home in which there is illness or pain and not offer assistance. The interactions created a particular rapport among all the participants. Cancer is imbued with supernatural beliefs and almost is considered a taboo subject; thus a deep level of comfort, trust, and even friendship needed to be established before wives and their families would discuss the subject (see Atobrah 2009; Antwi & Atobrah 2009). Questions were open-ended and value-free to avoid luring respondents into giving particular responses. Although the subject of the research evokes emotions of sympathy and empathy, at every stage of the study, from data collection through analysis, we have tried to confront our biases and remain as objective as possible in our observations and conclusions.

Husbands’ Care of Wives with Cancer

As discussed above, the study focused on three categories of care provided by husbands: material, practical, and emotional.

Husbands’ Material Care

Cancer treatment is very expensive for the average Ghanaian family. Household incomes are generally low, with an average annual gross household income of

Description of Study Participants

Case No.	Wives and Husbands	Background
1	Abigail	Age 34. Cancers of the breast and ovaries. Tertiary education and regular employment since her diagnoses five years earlier. She and her husband were dating at the time of her breast cancer diagnosis and subsequent mastectomy, which he knew about. They were married a year later. Abigail was later diagnosed with ovarian cancer and had a hysterectomy and other surgeries. The couple had no children and lived in rented premises.
	Ablor	Age 38. University education. Owner of a budding IT business. His office was about 100m away from home. He was the only son of his parents, and his logo design was the winning entry for a major public corporation.
2	Clara	Age 47. Breast cancer. Secondary education. She worked as a secretary in the public sector until the terminal stages of her illness. She had had a mastectomy and lived with her husband of 20 years in a rented apartment. She and her husband had been building an elegant home just before her diagnosis. They had four children, ages 18, 15, 13, and 10.
	Commey	Age 52. Secondary education. Owner of a successful construction company and earning a high income from government contracts.
3	Dodua	Age 48. Endometrial cancer. No formal education. Engaged in petty trade until the terminal stages of her illness. She had had several radiotherapy sessions but no surgery because the tumor was inoperable. Lived with her husband and four children in his family home.
	Darku	Age 49. No formal education. He had once been a farmer but was unemployed at the time of the study.
4	Korkor	Age 54. Breast cancer. Primary school education. Worked as a market trader until she became too sick to maintain her business. She had been married for about 25 years and the couple had four children, two of whom were married and had left home. The other two were at university.
	Kotey	Age 56. Primary school education. Worked as a taxi driver and seemed to have a substantial income.
5	Mamle	Age 57. Ovarian cancer. Secondary education. Worked as a manager at a financial institution before her diagnosis but retired soon after. She had had a hysterectomy and lived with her husband of over 30 years in a house they had built together. They had three adult married children.
	Moffat	Age 59. Owner of a printing business that had been successful until about four years prior to the study.

Note: All names are pseudonyms.

about GH¢ 6,645.00 (GSS 2014), while patients have to pay near “international” rates for chemotherapy and radiotherapy treatment.⁷ The National Health Insurance Scheme (NHIS), launched in 2003, covers the cost of consultation and surgery at the Korle Bu Teaching Hospital. However, the government is slow to reimburse providers, and in reality many patients end up paying out of pocket because providers are reluctant to accept or treat patients who are dependent on the national insurance. Further, patients have to bear incidental costs such as hiring taxis to and from the hospital, following special dietary requirements, and purchasing cleaning materials and personal hygiene products. For many patients the financial burden of cancer, especially when it also involves the loss of the woman’s income, is almost as enormous as that of the disease itself. For all the women in this study, the financial responsibility, along with expectations for such support, was largely shouldered by the patient’s spouse. In line with expectations for good senior men, health workers as well as relatives of both husbands and their sick wives expected husbands to rise to the financial challenges brought on by the illness. Clara expressed her expectations of her husband thus:

At the initial stages of the illness, my husband felt the health workers were demanding too much money so he stopped paying for treatment. Whenever I go to the hospital and I am not able to buy all the drugs prescribed, the nurses would ask, what work does your husband do? When I say he is a businessman then they would exclaim, “then take money from him to buy your drugs, he is your husband!” I thank God that now he helps me and gives me money often.

Three of the five husbands—Ablor, Commey, and Kotey—were not high-income earners, but they willingly mobilized funds from children, relatives, and friends to pay medical bills. Kotey said he had taken a loan from the bank to pay for each of the three cycles of chemotherapy for his wife. He felt no resentment about this, because he saw it as his duty:

Can you imagine what people will say if they hear that I cannot look after [provide financially for] my wife now that she is sick? I have to find the money, otherwise if something happens to her now [i.e., death] her family will not let me have peace.⁸ They will put a heavy debt on me. . . . As for the money, it is not there, but no one will understand that your wife is sick and you cannot find money. . . . Her family can help [financially], but you have to find the money because you are the man.

According to Ablor,

As the husband, I cannot sit down and not do anything. We have spent a lot of money since the sickness started, but what can I do? My friends understand my situation and lend me money when things become tough. If I don’t get the money then it is a different case, but if I do not help at all,

then what is my use? I don't misuse money so that anytime it is needed I just give it. . . . You know, she has not really worked well since the sickness started about five years ago.

In most conversations about their husbands' care the wives, too, talked about the material and financial care they received. During the very first encounter with Abigail she praised her husband for his material support.

I need to read a lot about my condition on the Internet so he has connected Internet for me. . . .⁹ He also got me this decoder [for satellite television] so that I can listen to foreign preachers; the word of God makes me have faith to cope with my condition. . . . Because they have removed my womb and breast, I have menopause and I sweat a lot so he fixed the air conditioner over there for me. . . . I exercise sometimes, when I am a bit OK. My husband bought the training bike over there so I can exercise and keep fit.

By contrast, the other two husbands, Darku and Moffat, were not in the position to pay for their wives' care and they both had strained relations with their wives during the entire period of the illnesses. Moffat's business was in crisis, although his wife, Mamle, had worked as a manager in a financial institution before her diagnosis and she continued to receive medical benefits from her previous employer. Nevertheless, Moffat's failure to provide for his wife's care seemed to place a strain on the relationship, although the couple had had marital conflicts even before the diagnosis.

Dodua's husband, Darku, was unemployed and struggling just to provide for the couple's four children, ages ten to seventeen. Two years after her diagnosis and persistent illness—which involved the need for a special diet and regular blood transfusions—Darku took Dodua and their children to live with her maternal aunt and then left, likely to escape from the embarrassment of his inability to protect and provide for his wife. He did not return until she died eleven months later.

Husbands' Practical Care

None of the husbands contributed significantly to the physical care of their wives, not even at the end stages of the disease when the patients became critically dependent on others for basic daily care. There were no observations of, or reports of, men helping with the feeding, bathing, cleaning, or toilet needs of their wives. Until they became critically ill, the wives had been responsible for household work, and even during the illness none of the men cooked or did the laundry, even their own. Husbands also seldom accompanied their wives on routine hospital visits, and when their wives were admitted to the hospital it was a daughter or other female relative who became the primary caregiver.¹⁰

Abigail had had four surgeries for breast and ovarian cancers and several cycles of chemotherapy. On each occasion she moved to her parents' home so her mother and sisters could care for her. "I don't want to

burden him [Ablor],” she said, “so I go to my parents. During those times I feel very sick and vomit a lot. He cannot do the things that my mother and sisters can do for me.” Once she felt somewhat better she would return to her marital home so that, as he mother put it, “she could go and look after her husband and home.”

Many wives also made excuses, at least at first, for their husbands’ inability to do the housework or involve themselves in practical care. “He is a man, what can he do?” Korkor said. “He does what he can, but you know our men, they do not touch things with their hands.” Korkor’s husband, Kotey, a taxi driver, never gave her a ride to the hospital; she had to go on her own even for chemotherapy infusions. When asked about this she said “he does not take me to the hospital because he has to leave the house very early in the morning for work.” It was observed, however, that Korkor herself left for the hospital as early as 5:30 a.m. to avoid standing on long queues. Generally, wives were aware that they were perceived as burdens to their families and endeavored not to worsen the dispositions of their caregivers by nagging and complaining about so-called mundane issues. Both Korkor and Kotey were also leaders in their church, and it was obvious that Korkor wanted to avoid portraying her husband as a “bad” Christian.

By the third or fourth interview, however, about four weeks into the study, many apparently felt relaxed enough to talk about these matters, frequently introducing a veiled or not-so-veiled complaint with a remark such as “I have not told anyone about this” or “I feel shy to say it but it is the truth.” Others who had been chronically ill for quite some time seemed exasperated enough to complain. Clara, for example, who had had a mastectomy about two years earlier, was exhausted by the demands of housework in addition to her formal work as a secretary. She had not disclosed her illness to her children, including her eldest daughter, an eighteen-year-old university student who was away from home most of the time. She thus had to act “normal” and continue to do most of the household tasks. On Saturdays she did the laundry, by hand, for the entire family—her husband, the two younger children, and herself. Her husband, Commey, was very fussy about his meals and seldom ate food prepared outside the home, and so she continued, with some help from her children, to prepare all the household meals early in the morning before going to work. If she was too ill to cook she had to arrange for help from her sister, although her sister was not always available. Clara once said of her husband, “His head is hard [he is mean]. He does not have mercy on me at all.”

Husbands’ Emotional Care

The wives in the study often expressed disappointment that their husbands did not show enough affection or comfort them during the most challenging periods of their illness, particularly when they were depressed or in physical pain. Abigail said, “When I return from the hospital, he doesn’t even ask me what the doctor said. Although he is not quarrelling with me,

it seems he does not want to see me, so the moment I am in the house, he pretends he has to go to this place or that place." Some husbands even suggested that the cancer might be the wife's fault. Dodua said that when she was diagnosed with end-stage endometrial cancer her husband, Darku, ignored and neglected her, accusing her of having contracted the disease through an extramarital affair. Clara said that

Right from the day the doctor said it was breast cancer, he said why is it that of all his brothers' wives I am the only one who has to get cancer. Then I asked him, "If why me, then why should it also be somebody else? It is only God who knows." . . . Then he said it is because I have done something to someone, that is why I have it, and that my bad character has brought this on me. . . . When he said this I wept bitterly and prayed for God to forgive him. . . . Just see the words that came out of his mouth at a time that I was expecting him to console me. . . . Then one day he asked me, "Is your God not able to heal you of this cancer"? When he said this, I exclaimed, "[Commey!] now you are going too far, are you the one to question God?". . . He really makes me feel very miserable.

All of the couples in the study indicated they were Christians, yet the wives reported that their husbands did not pray with them or read scriptural texts to encourage them. They also complained that husbands failed to offer simple gestures of physical comfort and affection. Though such behaviors, indeed, are not common among Ghanaian husbands, the wives were disappointed that they did not adjust their behavior in this extraordinary circumstance. Abigail said that

My husband tries to make me happy sometimes, but his problem is that he is too glued to his work. . . . Although he is doing his own work [i.e., has control over his own time], he closes very late and sometimes comes home after 10:30 p.m. I feel so lonely all the time and it is frustrating that they have removed my womb because of this illness so I cannot even have children to keep me company.

When asked why she didn't keep him company in his office or suggest that he bring work home she replied,

He says he cannot concentrate when I am around, and you know, he is someone who does not compromise his needs, especially if it has to do with his work, because he says that is his source of joy, fulfillment, and sustenance. I just think he cannot stand seeing me. . . . I think it worries him.

Indeed, Ablor worked hard, as we have seen, to provide Abigail with material indulgences—a satellite television, an air conditioner, Internet access, and an exercise bike. But she missed his company and craved warmth, encouragement, and affection.

Unlike their wives, none of the husbands overtly expressed fear, distress, anxiety, or worry. Instead they seemed withdrawn, especially during the wives' final days, and eventually stopped sharing the marital bedroom. But throughout they remained punctual at work, in some cases leaving the house very early in the morning and returning when household members were asleep.

Although the subject of sexual relations was not considered during the design stage of the larger study and therefore not included in the research protocol, it emerged in the conversations. In all cases the disease affected sexual intimacy, and both wives and husbands were bothered about this, albeit for different reasons. Three of the wives—Abigail, Clara, and Dodua—became very suspicious that infrequent sexual activity was the reason that their husbands had withdrawn from them. Commenting on her husband's sexual promiscuity, even before the illness, Clara said "Even when I had both breasts it [the marriage] was not easy and now I do not know. . . ." Abigail said, "When my husband stays so late in his office, I feel like going there to see if he is really there or if there is another woman there. I went a few times and he was really there with his male friends but I'm still not sure." Husbands, for their part, found that their own sexual desires toward their wives were also affected by the illness. About his wife, Korkor, Kotey said, "She has changed. . . . When she sleeps and I look at her, the feelings do not come like it was at first." Clara recounted how her husband, Commey, complained about feeling nauseated whenever he had sex with her, and that he believed he was being affected by the chemotherapy she had received. He explicitly asked her to allow him to marry another woman because he could not sacrifice his sexuality "for her illness."¹¹ Clara suggested that they consult her surgeon about any possible effects of the chemotherapy on a spouse, and the doctor of course said there were none. Nonetheless, Commey continued to complain. On one occasion when Clara was scheduled for a cycle of chemotherapy Commey remarked, "so you are going to do this thing again so that all your hair will go away eh?"

According to statements made by husbands, mostly after their wives' deaths, their emotional withdrawal may not have been caused by callousness or a lack of caring and sympathy, but rather by their frustrations with their own inability to "save" their wives. Cancer survival rates in Ghana are low (Clegg-Lamptey, Dakubo, & Attobrah 2009), and most people construe a diagnosis as a death sentence. "It was very difficult to look at your wife when you knew she was dying and you could not do anything about it," Kotey said. "You look at your children and you didn't know what to tell them, . . . and as their father I could not do anything." Of course, once a woman died it also was important for the husbands to talk about the efforts they had made to seek treatment and a cure, probably to evade the accusation of not having done enough to "save" their wives. After Korkor died Kotey said, "If there was anything on earth I could have done to save her, I would have done it. We never relented in our efforts to cure her, but God has done what pleases him. . . ."

Discussion and Conclusions

Although the construction of illness is culturally specific, cancer generally evokes fear, anxiety, and distress across cultures and patient care requires the involvement of all family members. Without attempting to evaluate the responses of all Ghanaian husbands to the needs of their sick spouses, our analysis of this small population from Accra suggests that the ideals of dominant masculinity are not easily negotiated and compromised in men's care of wives diagnosed with cancer. Although there is evidence that in changing socioeconomic circumstances some men are taking on traditional "female" roles in the world of work, and even do well in their "re-gendered" occupations, they appear less willing to assume "female" roles at home (Agadjanian 2002; Lindsay 2005) and marital relations remain patriarchal both practically and symbolically. According to accepted conjugal roles, domestic work is also women's work—meaning that it is inferior and that it would be demeaning and emasculating for a man to engage in it. Wives themselves reinforce the normative practices in the household and excuse the husbands for their failure to participate in practical care. These normative practices are also enforced and policed by families, the community, and society at large, to ensure conformity (Meischer 2007; Adomako Ampofo et al. 2009).

At the same time that hegemonic masculinity releases men from housework, it also imposes responsibilities on men to conform to the ideal role of "provider" and "breadwinner." Faced with huge medical expenses, however, and no longer able to count on the salaries of working wives, many husbands of wives with cancer are unable to live up to these expectations for material provisioning and protection. In several families that we studied the burden of providing materially for wives was unbearable to the men, and husbands preferred to place wives with relatives rather than confront their own failures. Of course, emotions are also culturally constructed, and it is possible that these men withdrew emotionally because they themselves could not effectively manage their own distress and frustrations associated with their wives' diagnoses. Husbands who continued to expect the usual domestic services from their sick wives, along with regular sexual intimacy, certainly hurt their wives considerably, but they may themselves have been living in denial.

Although our sample was small one, we venture that in the absence of any previous studies in this regard the findings are important for assessing the care chronically and terminally ill women receive, and feel entitled to receive, from their husbands. We suggest that dominant and ruling masculinity influences husbands' care responses to their wives' cancer diagnoses. Consistent with other studies, men's care was of a lower quality than care women typically provide, was for short periods, was mostly instrumental, excluded involvement in the arduous daily tasks of practical caregiving, and was lacking in emotional support. Nonetheless, it is important to acknowledge that using feminine standards of care to assess men's caregiving is problematic. Further studies are needed to measure men's own experiences of

distress and their particular coping mechanisms. In addition, because ruling masculinity is closely associated with senior masculinity, this research needs to be replicated with larger and more diverse groups of spouses, including younger and more socially and economically diverse couples. Such studies should provide some insight into whether, and how, qualities of femininity and masculinity exhibit themselves in the care of terminally ill spouses across demographic groups.

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Notes

1. An example of financial compensation is the Dependent Care Tax Credit of the United States.
2. In Ghana, we are aware of Reach for Recovery as the only agency that provides paid home care services, although it is private and not licensed. It also provides training for homecare workers.
3. The proportion of married women in Ghana who were in polygynous unions declined from 33 percent in 1988 to 18 percent in 2008 (GSS 1989; GSS 2008). Pseudo-polygyny is an arrangement in which seemingly monogamous men married under ordinance maintain other secret, unofficial, and illegal families.
4. Gibson-Graham, Resnick, and Wolff (2000) explore ways in which alternative theories of class and an associated "re-theorization" of social and personal identity "can make visible a politics of class that is largely invisible in restructuring research" (200:48). For example, both the women's and the environmental movements have generated new discourses of (social and ecological) identity that have had major impacts on distributive processes and justice.
5. An extensive literature on gender relations in Ghana exists, but for reasons of space we only summarize it here. See Yeboah et al. (2014) for a review.
6. The notion of the "Big Man" has come to have negative connotations because of its association with corrupt politicians. While *panyin* is a gender-neutral term that can refer to women, the concept today is typically associated with maleness,

and senior men who do not acquire this status are judged more harshly than women. The word means "elder" in Akan.

7. Going by the 2013 U.S. dollar-to-cedi exchange rate of about 1:2, an entire household would be earning about U.S.\$3,322 annually. Chemotherapy and radiotherapy cost an equivalent of about U.S.\$200 per session.
8. It is common for relatives to harass a widow or widower if they suspect that the death of a spouse was the result of negligence, irresponsibility, or failure to perform his or her marital obligations.
9. Most households in Ghana do not have Internet services at home, much less cable television, although people do use their mobile phones to access the Internet.
10. Although many homes in Accra employ a household helper (Tsikata 2014), none of the households in the sample had one. Dodua's aunt, with whom she lived until her death, ran a home catering business, and several employees who assisted with domestic work helped take care of Dodua.
11. The couple were married "under the ordinance" and remarriage without a divorce would constitute bigamy.