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'Why give birth to many children when you cannot take care of them?' Determinants of family size among dual-earner couples in Ghana

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Abstract

The family size in Ghana is increasingly changing from large to small family sizes due to modernization. As societies become modernized, couples begin to limit their family size despite the high value society places on children in marriage and the family. In this study, we explore the factors influencing reproductive behaviour among Ghanaian dual-earner couples by highlighting the subjective views on factors that influence the number of children they have or hope to have as a couple. A qualitative approach was used to collect and analyse data. Data were gathered through in-depth interviews with 47 dual-earner couples from rural and urban communities selected from five regions in Ghana. Twenty key informant interviews were held with community leaders to provide the social context of the study areas. The data were analysed thematically. The study observed that there were no differences in the factors influencing family size in rural and urban communities in Ghana. Also, the findings are consistent with previous studies that identified factors such as the cost of raising children and women's participation in the labour force although the meanings and interpretations that couples attribute to these factors have changed slightly. Couples' family size was influenced by the need to ensure a comfortable life for their children. Access to modern contraceptives and infertility also came up as influencing family size. Overall, the changing family size among dual earner couples can be attributed to a combination of factors that are interrelated and interdependent.

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Introduction

Globally, there has been a decline in fertility rate although the distribution is not proportional across countries (De Silva and Tenreyro, 2020). Whereas some countries, mainly the developed countries have experienced a rapid decline in fertility rate, the decline rate is slow in sub-Saharan African countries (Bongaarts and Casterline, 2013; Shapiro and Hinde, 2017). Shapiro and Hinde (2017) observed that comparatively, fertility decline in sub-Saharan Africa was slower than the earlier declines in Asia, Latin America, the Caribbean and Northern Africa. This observation suggests that there are variations in fertility rates across regions as well as within regions. In a study on sub-Saharan Africa, Casterline and Agyei-Mensah (2017) conclude that family size was a result of conscious desire to limit family size. However, they further argue that such desires remain low. They found that in almost all sub-Saharan African countries, just a small minority of women indicated a desire to stop at two births, and in a majority of countries most women who already had four births wanted to have another child (Casterline and Agyei-Mensah, 2017).

In Ghana, fertility decisions have been influenced by different factors over the years. Most families in traditional Ghanaian society valued children for varied reasons such as source of security in old age, labour force, marriage stability and prestige (Dyer, 2007; Oheneba-Sakyi and Baffour, 2006; Tabong and Adongo, 2013b). Children were valued as a source of security because they were expected to take care of their parents in their old age. In addition, children were a source of labour for the family, especially in farming and fishing communities, thus having more children meant having more hands to work to accumulate wealth. A childless marriage was seen as a 'trouble marriage' (Dyer, 2007; Dyer et al., 2004; Fledderjohann, 2012; Tabong and Adongo, 2013a), to the extent that childless couples were not considered as a 'complete family' in traditional Ghanaian society (Nukunya, 2016). Thus, having children was cherished in the Ghanaian traditional society and women who had several children were rewarded (Caldwell and Caldwell, 1987).

However, over the last decades, the notion of having many children is changing with couples reducing the number of children they have in their lifetime (Kodzi et al., 2012; Montgomery et al., 1995). Social and economic developments such as urbanization (Dzegede, 1981; White et al., 2005), migration (Caldwell, 1968; Oppong, 1977; Oppong and Abu, 1984), new occupational structure (Abraham et al., 2017; Concepcion, 1974), and increased education (Adomako Ampofo, 2002; DeRose et al., 2010) have been identified as the main factors influencing reproductive behaviour among couples. Most of these studies that seek to explain reproductive behaviour, especially regarding the number of children among couples, have used the quantitative approach, thus giving us the objective views on the changing fertility behaviour (Kodzi et al., 2010; Mönkediek and Bras, 2018). Only a few studies have explored factors influencing Ghana's fertility transition focussing on views of couples using a qualitative or mixed

method approach (Agyei-Mensah, 2007; Anarfi, 2003; Bongaarts, 2017; Caldwell, 1968; Chuks, 2002; Oheneba-Sakyi and Baffour, 2006), hence our interest in contributing to this discussion.

In this study, we highlight the factors influencing family size among dual-earner couples in Ghana, which according to the literature depends on a series of determinants that are strongly influenced by economic, demographic, and sociocultural factors. Dual-earner couples in this study refer to couples who both contribute to the income of their household through their work outside the home (Aronson and Aronson Paxton, 2007).

This article is divided into five main sections. In the 'Literature and theoretical perspectives on changing reproductive behaviour' section, we present the literature and theoretical perspectives underlying the data analysis with emphasis on the preference theory (Hakim, 2003) to explore the factors influencing family size among dual-earner couples. The 'Study area and methodology' section outlines the methodology used in the collection and analysis of the data. This is followed by the 'Result and discussion' section that presents the results and discussions of the study and the 'Conclusion' section that states the conclusion of the study.

Literature and theoretical perspectives on changing reproductive behaviour

Understanding the factors influencing reproductive behaviour among couples in Ghana can be a complex venture due to the diverse forms of family structures. Ghanaian family structures may be influenced by the type of residence (rural or urban), type of marriage (monogamous or polygynous) and/or type of family (nuclear or extended) as well as the diverse sociocultural factors. The Ghanaian society can be largely described as becoming increasingly modernized, although some traditional practices persist thus affecting the reproductive behaviour of some couples. Traditional Ghanaian society refers to pre-colonial Ghanaian society – Ghanaian society before the advent of colonialism that was non-literate and 'characterized by hereditary succession, age as a basis of status and rigid adherence to custom' (Nukunya, 2016: 9). The traditional Ghanaian society was largely patriarchal, regardless of whether one belonged to the matrilineal or patrilineal descent group and inclined towards the extended family system. The patriarchal nature of the traditional society allowed men to influence every decision in the household, including women's reproductive health (Ganle et al., 2015). However, in contemporary Ghanaian society, most families have moved towards the nuclear family system as a result of formal education, urbanization, and migration (Kpoor, 2015). There is, however, a duality of practice in contemporary Ghanaian society where patriarchal norms continue to influence decision-making in the household and the family is seen as the basic unit for procreation (Nukunya, 2016). In both traditional and contemporary Ghanaian society, having children plays an important role in marriage as well as the family and therefore most couples, especially women, after marriage are highly expectant to bear children (Oppong and Abu, 1984).

Human reproductive behaviour forms the basis for the organization of the family in most societies, especially in African countries (Oheneba-Sakyi and Baffour, 2006), and thus, the need to factor in how the norms and values of the society together with the

current economic demands of the society influenced each other. In patriarchal societies such as Ghana, gender relations as determined by norms and values within a given social context influence reproductive behaviour. For instance, Adongo et al. (1997) in a study observed that due to the cultural values and norms in rural Northern Ghana, only few women see the decision to access contraceptives to be theirs. This is particularly the case in societies where gender relations are often guided by patriarchal norms that give men more power in decision-making in the household including women's reproductive health.

The demographic transition theory, however, explains fertility behaviour among couples to be the product of economic and social changes in the society resulting from urbanization, new occupational structure as well as increased education. Bongaarts (2017: 40) demonstrates how changes in the demographics influenced fertility transition by stating that 'a reduction in desired family size results from rising costs of children (e.g., cost of education) and their declining economic value (e.g., labour and old-age security), which are considered the central forces driving the transition'. This study extends the demographic transition theory by providing insights into how the social and economic developments determine family size among dual-earner couples in rural and urban communities.

Another theory for explaining reproductive behaviour is the preference theory. Hakim (2003), developed the preference theory to provide an alternative framework for understanding current changes in modern societies from a qualitative point of view. In the preference theory, preferences are the primary determinants of fertility and employment decisions among women (Hakim, 2003). The preference theory focusses more on personal values and decision-making at the micro-level. 'It also specifies the particular social, economic and institutional contexts within which preferences become the primary determinant of women's choices' (Hakim, 2003: 350). Although Hakim (2003) proposes five tenets to explain the fertility transition in modern society, this study adopts the first two to analyse the reproductive behaviour of dual-earner couples in Ghana. In the first tenet, Hakim identifies historical changes in society and the labour market as playing an important role in fertility transition. This tenet argues that changes in society such as the availability of modern contraceptives plays a role in the reproductive behaviour of couples. Again, the equal opportunity created for both sexes to access formal education which, in the end is expected to provide equal opportunity for both sexes to engage in paid employment also influences the reproductive behaviour among couples. In this study we focus on the influence of what Hakim (2003) refers to as the contraceptive revolution and equal opportunity revolution to provide insight into dual-earner couples' reproductive behaviour in terms of their preferred or desired number of children.

The preference theory also focusses on the heterogeneity in women's preference between employment and family. It posits that when women have a choice, they choose among three different lifestyles: adaptive, work-centred and home-centred, suggesting that there are three categories of married women (Hakim, 2003). Adaptive women prefer to combine employment and family work without giving fixed priority to either. Adaptive women preferred flexible occupations such as teaching, trading, or operating shops from home or take up jobs that are part-time (Hakim, 2003; Teye, 2013). Work-centred women engage in competitive employment, and they adjust their family life to the dictates of their career and may choose to remain childless, even when married. The assumption that

work-centred women may prioritize their employment over their family to the extent of remaining childless sometimes may not always be the case, as other studies also suggest that career-centred women may compensate for their frequent absence from home most of the time, by employing or seeking assistance with childcare (Okafor and Amayo, 2006). Home-centred or family-centred women give priority to family life when they marry. They are most inclined to have larger families and these women avoid paid work after marriage unless the family is experiencing financial hardship. Although the preference theory brings other dimensions to explaining fertility transition, Teye (2013), criticizes it for assuming that fertility preferences of women always determined their actual fertility levels. Our study provides more insight into the various factors that combine to influence women's fertility behaviour, aside a woman's own preference. We argue that in as much as the preference theory may explain a woman's reproductive behaviour, the cultural norms and values in the society can also influence a woman's preference.

Study area and methodology

Most studies on determinants of reproductive behaviour among families have used the quantitative approach to investigate and explain the phenomena. Such one-sided approach does not provide the subjective meanings people have for their behaviour. To complement such studies, the current study employed a qualitative research design. The study was conducted in five regions in Ghana, namely Ashanti, Greater Accra, Northern, Upper East, and the Volta Regions to reflect the five major ethnic groups in the country. The five major ethnic groups include the Akan, Ewe, Guan, Ga-Dangme and Mole-Dagbani. In each identified region, one rural and one urban community was selected for the study to bring out the rural and urban differences and similarities that influenced couples' reproductive behaviour. In-depth interviews were used to collect data from couples who have been married or been in a consensual union for more than 2 years. To provide an in-depth knowledge of the context informing and influencing the reproductive behaviour of the participants, key informant interviews with personalities such as traditional leaders, religious leaders, opinion leaders as well as community leaders were conducted in each community.

Participants for the study were selected through purposive, quota, and snowball sampling techniques. The inclusion and exclusion criteria focussed on the type of union (married or consensual union), length of the union (more than 2 years) and employment status (both couples earn income). The study selected dual-earner couples who were either married or in a consensual union, living together, had been in the union for more than 2 years and have at least a child. The quota sampling technique informed the selection of participants to ensure that couples from low-, middle- and high-income brackets were represented. In each region 10 couples were selected, five each from a rural and an urban community. Ten couple interviews were conducted in the Ashanti Region, Northern Region and Upper East Region. In the Greater-Accra Region and Volta Region, eight and nine couple interviews were conducted, respectively. The final sample (47 couples) thus provided the subjective views of couples with diverse cultural values and norms as well as socioeconomic background on factors that influenced their reproductive behaviour with emphasis on the preferred number of children.

The purposive sampling technique was used to select two key informants in each community (one male and one female). These key informants provided the background information as well as the social context of the various communities in which the study was conducted.

The data were collected through in-depth interviews with couples and key informants in the selected study areas. Three distinct semi-structured interview guides were used to collect the qualitative data for the study. The interview guide for wives focussed on soliciting information on their fertility choices and how they negotiated their fertility outcomes. For the husbands, they were interrogated about their role in women's fertility outcomes. The key informant interview guides asked questions that provided insight on the contextual explanations for the experiences of couples with regard to their fertility outcomes. In those localities where the researchers did not speak the local language, interviews were conducted with the assistance of interpreters. All interviews with the couples were conducted separately, although the interviews for both spouses were conducted simultaneously. All interviews were carried out in the homes of the participants. The interviews were audio recorded with the permission of the participants. All the 20 key informant interviews with opinion/community leaders from both the rural and urban areas are included in the analysis. To ensure adherence to cultural values and norms in the Ghanaian society, interviewers and interviewees were paired taking into consideration the gender of each pair, thus, males interviewed male participants and females interviewed female participants.

The audio recordings of discussions held in English were transcribed, and recordings in the local language of participants were translated and transcribed simultaneously. Thematic analysis was used to analyse the data (Attride-Stirling, 2001; Braun and Clarke, 2006). As suggested by Braun and Clarke's (2006) six-step model, the analysis started with data familiarization. After transcribing the data, the researchers attentively read through the transcripts to fully understand the content of each transcript and noted down some ideas for coding on each transcript. Data extracts were grouped according to the identified codes to obtain an overview. The codes were generated by highlighting interesting and recurrent features from the data in a systematic manner. This was followed by the collating of codes into themes. The researchers identified themes by combining different codes, which focussed on a common subject. After organizing the codes into themes, the initial themes were further reviewed and refined, thereby generating main themes and sub-themes. The final themes were selected by utilizing the two levels suggested by Braun and Clarke (2006: 9), where at level one, the 'candidate themes formed a coherent pattern', and at the second level, the candidate themes reflected 'the meanings evident in the data set as a whole'. To avoid any overlap of codes, the themes were defined and refined to ensure that each theme was distinct in the story it told.

Result and discussion

Socio-demographic characteristics of couples

The ages of the couples who participated in the study ranged from 20 to 70 years. Out of the 47 couples, most husbands (81%) were older than their wives, 9% of the wives

were older than their spouses, 4% of the couples were of the same age and 6% do not know their age. The educational background of the couples ranged from no education to tertiary education. Approximately 52% of the husbands had a higher level of education relative to their wives, whereas 19% of the wives had a higher level of education relative to their husbands or partners and 28% had the same level of education. The difference in educational attainment of the couples is reflective of the general gender gap in educational attainment in the wider Ghanaian population. The religious background of the couples cut across the three main religions in Ghana. Majority (70%) were Christians, while 26% were Muslims and the rest (4%) were traditionalists. As expected, most of the Muslim participants were found in the Northern Region of the country based on the 2010 housing and population census. The number of childbirths among couples ranged from one child to as many as eight children with the average number of children per a couple being three.

Earning differentials were observed among couples. The data indicate that 45% of the wives had spouses who earned a higher income than they did, while 28% of the wives earned a higher income relative to their spouses. In a few instances (7 couples), there was lack of consensus on who earned more or less among some couples. In terms of sectors of employment, approximately 64% of the couples were both working in the informal sector and 21% of the couples were both working in the formal sector. Six percent of the wives worked in the formal sector while their spouses worked in the informal sector and 9% of the wives worked in the informal sector while their husbands worked in the formal sector.

Rising/high cost of raising children

The financial cost of raising children was identified by majority of the participants as influencing their decision on having children as well as the number of children to have. According to participants, the number of children they prefer to have is based on their economic strength. This view cuts across both rural and urban communities. Below is a representative view of the participants:

> . . . Yes, the number of children you want depends on the amount of money you make . . . someone can decide to give birth to thirty children, and someone can also decide to have six children. I felt I could take care of six, so I have six children. (Mr Agyei, 53 years old with 6 children, Rural Ashanti Region)

> Money is difficult to come by and I do not have a stable income. We thus decided that in order not to strain my husband's income, it would be better to stop having any more children. (Eno Pokua, 35 years old with 4 children, Urban Ashanti Region)

A great number of couples in both the rural and urban communities identified the cost of education as influencing their family size. In Ghana, education in public schools at the basic level is largely free. Free education at the basic school level covers the cost of tuition, feeding and educational materials. However, parents must pay for other direct costs of education such as school uniforms, extra classes, and examination fees, hence increasing the household's expenditure on education (Akaguri, 2014). Secondary education

became totally free in 2017, and covers cost of tuition, feeding, uniforms as well as educational materials. Nevertheless, Addae et al. (2019) in a study on Ghana's free education have argued that free SHS is not absolute in terms of cost since parents had to pay for other costs, such as transportation, pocket money for other expenses, purchases of bag and baggage for those going to boarding schools.

These attendant costs relating to education presents real challenges to families in Ghana. According to most couples, their desire to provide a good education for their children is a major factor determining their family size. A participant explained,

> . . . I have decided not to give birth again. The amount of money in school fees demanded by the school is a lot. Besides, they are increasing. I alone I have 3 kids and the oldest is in JHS 2, so right now I am preparing towards her SHS education. Our father did not take care of us. My mother single handed took care of us and I realized that it was because we were many that was why she struggled in taking care of us. (Naa Koshie, 34 years with 3 children, Rural Greater Accra Region)

Although education is free in public schools, parents who prefer private schools must pay school fees. These findings confirm earlier studies which suggest that the high and rising cost of education is still a major determinant of family size in Ghana (Caldwell, 1968). Most of the concerns raised by parents on the financial cost of education aligns with aspects of the demographic transition theory that suggests that a reduction in the desired family size results from rising costs of children's education. This issue was raised in both rural and urban communities. Thus, even though the government has absorbed most of the cost of education at both the basic and senior high school levels, parents still have a challenge meeting the educational needs of their children. Nukunya (2016: 201), explains that 'the need to send children to school has changed the position of children as economic assets to that of a drain on the parents' resources, thereby forcing people to limit their families to manageable size'.

Ensuring a comfortable life for children

Aside the rising cost of raising children, participants expressed the desire to give their children a 'good life' and, thus, they were of the view that limiting the number of children they have gives them room to achieve this. According to most of the participants, being able to provide the basic needs of their children amounts to giving them a good life. Participants in the urban communities explained that the main factor influencing their family size was more of being able to take care of their children.

> Taking care of children these days is difficult. So now, we must work to build a home for them so that they have a good life instead of giving birth to plenty without a good home for them. So, we considered the number of children we can cater for and what we can do for them so that when they grow up, they can have a good life. (Dzifa, 37 years old with 3 children, Urban Volta Region)

Similarly in the rural communities, the value of having several children has declined with most couples reducing the number of children they have based on how many they can take good care of.

> It is not easy to take care of children nowadays. Previously, people were giving birth to lots of children. But now, you can give birth to one child, and if only you take care of that child well, he/she will grow up to be a better person in life. (Nii Ankrah, 49 years, with 2 children, Rural Greater Accra Region).

Naa Koshie, a mother of 3 in Rural Greater Accra, explains the factor that determines her preferred family size:

> There are a lot of gossips in this community. People poke their noses where they are not supposed to. I do not want people to point fingers at me saying that I have given birth to plenty children, and I cannot take care of them. Three [children] is enough for me. (Naa Koshie, 34 years with 3 children, Rural Greater Accra Region)

Couples are of the view that when they have fewer children, they will be able to provide the basic needs of their children. Although historically, the Ghanaian family structure was extended with extended kin playing a key role in raising children, the study has revealed that the notion of taking care of children is increasingly becoming the total responsibility of the nuclear family who are expected to provide the basic needs of children such as clothing, food and shelter.

In addition, due to the communal nature of rural communities, where there is face-to-face interaction, pressure from community members tend to influence couples' fertility behaviour. Couples are concerned about how community members perceive them in terms of how they take care of their children, as such, they limit the number of children they have in order to be able to take good care of them to avoid gossips or labelling by their community members. The reaction of members of the society to families who are not able to take care of their children supports Newson et al.'s (2005) argument that social influence plays an important role in determining reproductive behaviour.

Women's participation in the labour market

Existing literature has always shown that the Ghanaian wife had always worked both in the home and out of the home (Caldwell, 1968). However, a key informant from rural Ashanti held a different view. According to the key informant, in the traditional family system, the division of labour was such that husbands worked and provided for the family's needs, whereas wives took care of the home by performing domestic duties. The key informant shared his view on women's traditional work in rural communities:

> Previously, in our culture, women were not allowed to undertake any economic activity. What was expected of a woman by way of work was to sweep the house, fetch water for the husband to bath and give him food to eat. All the house chores were the responsibility of the woman. The man was expected to also go to the bush either to farm or do something to bring money. No man even wanted their wives to do any economic work. They go out to work, cultivate cocoa and bring the money home to the woman. (Wofa Badu, Male Key Informant, Rural Ashanti Region)

Although this assertion could be true, it cannot be generalized for all women because there are studies that indicate that some wives worked outside the home. In a study on Ghana several decades ago, Caldwell (1968), observed that three-fifths of women were

in employments other than 'home duties'. The trend of women working or participating in the labour market to support their families persists even in contemporary times (Abraham et al., 2017). Women continue to participate in the labour market, thus the phenomenon of dual-earner couples persist in both rural and urban areas. Women from dual-earner families worked in either the formal or informal sectors. Most women working in the formal sector were in the urban areas as teachers, bankers and nurses, whereas in the rural areas, most women working in the informal sector engaged in farming, trading, hairdressing/tailoring or food vending. Women's participation in the labour force influenced their family size in different ways. First, we identified families where women and their spouses limited the number of children due to the woman's career. Some women who were career-centred lamented about the effect of having children on their career and, thus, their decision to limit the number of children they bear. A dressmaker explained the reason why she believed she was not going to have any more children:

> I am not going to give birth again. It is a decision by both of us. I told him (spouse) that I was not going to give birth to too many children. I will not even give birth to four children. It is because of the kind of work I do. If you choose to give birth to many children, you would not be able to do the work. (Naa Koshie, 34 years old with 3 children, Rural Greater Accra Region)

The position of the woman in this family places her under Hakim's typology of job-centred woman. According to Hakim (2003), work-centred women engage in competitive employment and they adjust their family life to the dictates of their career and may choose to remain childless, even when married. Given the cultural value of children in the Ghanaian family and marriage, women would rather limit the number of children they have, rather than opting to be childless because of their participation in the labour market. Thus, most wives with this background maintained their career but limited the number of children they bear.

Second, we also observed that in some families, they adapted to the situation because women changed jobs, especially women working in the formal sector moved to work in the informal sector because of their reproductive responsibilities. A participant in a rural community stated,

> . . . Yes, I stopped the work in the formal sector to move to the farm . . . I started farming full time when I stopped teaching. So when my husband leaves for work, I see to the children who are of school going age for them to go to school; after which, I would carry the youngest one at my back to the farm . . . (Daavi Feli, 42 years old with 4 children, Rural Volta Region)

In families where both couples are employed, women's participation in the labour market played a role in their fertility behaviour. Regardless of the sector in which women worked, the type of work influenced their reproductive behaviour. Most wives changed to more flexible jobs to be able to perform their traditional household duties as well as fulfil their fertility desires. This type of reproductive behaviour fits into Hakim's typology of adaptive women. Adaptive women according to Hakim prefer to combine employment and family work without giving fixed priority to either. Hence, families adapted their reproductive behaviours by opting for more flexible occupations (Hakim, 2003; Teye, 2013).

Access to modern contraceptives

Accessibility to modern contraceptives also came up strongly in both rural and urban communities as a factor influencing family size. Enrolling in a family planning programme was also influenced by the number of children a couple have. Access to contraceptives influenced family size in two ways. First, there were families where both couples relied on a family planning programme to limit the number of children. Such families were more common in the urban communities. For instance, Mr Agbo explained,

> It was after the fourth child that we (husband and wife) enrolled in a family planning program, we do not want to have children again because the four children we have are enough. (Mr Agbo, 39 years old with 4 children, Urban Greater Accra Region)

Some couples are making-decisions on family size together. This is often done after they have had the desired number of children they want. In other families, the wives influenced the family size by enrolling in family planning programmes without the knowledge of their spouses. As such, when wives attained their fertility desires, they turned to family planning programmes to avoid having more children. A participant, with five children stated,

> I am on a family planning program, but he (husband) is not aware . . . after I gave birth to the last born, I enrolled in a family planning program. (Mrs Ashitey, 29 years old with 2 children, Rural Greater Accra Region)

This strategy of unilateral decision-making on enrolling in a family planning programme was very common among rural women compared with their urban counterparts. In rural communities, where patriarchal norms are strictly adhered to, men had control over household decisions including reproductive health matters. We observed that some wives went against such patriarchal norms, by unilaterally deciding on their desired family size without the knowledge or consent of their spouses. With women increasingly having access to financial resources due to their participation in the labour market as well as women having access to some level of education, they can on their own act in ways to limit the number of children they have. With the introduction of contraceptives, some women do enrol in such programmes with or without the knowledge of their spouses, thus controlling the number of children they have as a couple. This finding supports Hakim's (2003) preference theory that attributes the changing trends in fertility to what she calls the 'contraceptive revolution'. To a large extent, the availability of modern contraceptives, which is a reliable source of managing fertility, has a role to play in the reproductive behaviour of couples. This notwithstanding, in a society where polygyny (a man marrying several wives) is allowed, women may suffer the consequences of not giving in to their spouses' fertility desires. The patriarchal nature of the Ghanaian society allows men to have several wives, and not vice versa. A husband may marry more wives to meet his fertility desires, if a wife refuses to have the number of children he wants (Agadjanian and Ezeh, 2000).

Infertility

Although the issue of infertility did not feature prominently in the data, it was observed that such factors influenced family size. A couple from a rural community in Ashanti Region and another from an urban community in the Greater Accra Region shared their experiences on how their inability to get pregnant after having a child influenced their current family size. Mrs Aboagye who has been married for 20 years explained,

> I stayed in my first marriage for seventeen years without getting pregnant, then I got divorced. I got pregnant exactly a year after I got married to my current husband . . . because I was taking a lot of medications to help me get pregnant, I had a problem with my womb during childbirth, my womb became weak, so I had to go through surgery after that I could not get pregnant again. (Mrs Aboagye, 57 years with a child, Rural Ashanti Region)

Mrs Aboagye's husband, when asked about the number of children they had in their family, explained,

> I have two children, one with my wife and the other with a different woman. Yes, she (wife) was not getting pregnant. After the first child, we were looking forward to a second child, but that did not happen. So, I realized she was not getting pregnant thus, I went out and gave birth with another woman . . . (Mr Aboagye, 53 years with 2 children, Rural Ashanti Region)

Mr Aboagye's strategy showed ways individuals still try and maintain control in determining their family size, despite the inability of the couple to have more children. This indicates that childbearing does not happen only among married women, but extra-marital sexual activity and childbearing may contribute to determining family size. Such strategies are socially accepted for men, thus allowing men to still have children with another woman.

Another participant in urban Greater Accra Region who has been married for 30 years also explained,

> . . . I have a single child because of my medical condition but it was not deliberate. (Mrs Lamptey, 59 years old with a child, Urban Greater Accra Region)

In the case of the Lamptey, both accepted their inability to have more children and that determined their family size. Ending up with a small family size was not deliberate on their part as a couple, but challenges with their reproductive health did not allow them to attain their preferred family size.

According to Bongaarts and Potter (2013: 171), 'The proximate determinants of fertility are the biological and behavioural factors through which social, economic and environmental variables affect fertility'. Thus, although family size may be determined by biological factors, where it is socially accepted, men may resort to marrying more wives or have an extra marital affair to bear children (Fledderjohann, 2012). The experiences of these two couples (Mr and Mrs Aboagye and Mr and Mrs Lamptey) provide insight into the different ways couples determine their family size despite their inability to have children as a couple. Whereas some men may choose to marry additional wives or have

extra marital affairs to have more children, women, however, cannot exhibit such behaviours due to sociocultural norms that frown on such behaviours from women. Thus, control over fertility issues can be said to be gendered, especially in patriarchal societies. In such societies, it is socially accepted for a man to marry additional wives or have extra marital affairs, while women, however, do not have such privileges.

Conclusion

This study explored the factors influencing family size among dual-earner couples in Ghana and observed that reproductive behaviour depended on a series of determinants that are influenced mainly by sociocultural, economic and biological factors. Using qualitative data collected from dual earner couples, the study observed that there were no differences in the factors influencing family size in rural and urban communities in Ghana. Also, the findings are consistent with previous studies that identified factors such as the cost of raising children and women's participation in the labour force although the meanings and interpretations couples attribute to these factors have changed slightly. Parents desire to ensure a comfortable life for their children determined their family size. We also observed that the family size was not only determined by women, but men were involved in the decision. Men played an active role when it came to deciding on the number of children to have as a couple. Despite the influence of modernity, there is still duality of practice, where women in most cases took such decisions with their spouses and often accept their spouses' decisions. However, some women had to be discreet when they enrolled in family planning programmes to control childbirth.

Most of the factors identified as influencing family size although analysed independently, are not mutually exclusive. Having children as a couple was an achievement in most families although we observed that the number of children desired or preferred varied for individual couples based on the number, they believe they can take good care of. There was no consensus among the participants on an ideal family size, hence, the preferred number of children was relative. Social esteem is no longer attached to the number of children, but the quality of care provided for the children (Bleek, 1982).

Closely linked to this is the cost associated with raising children. Although couples emphasized the financial cost involved, they also mentioned social cost. Families are of the view that the number of children must match the family's financial resources. Educating children seems to be a priority among both rural and urban dwellers, such that most families were concerned about the financial demands of educating their children. This suggests that the number of children may not necessarily be an issue of how many children, but rather what number of children can we cater for. Although the extended family continues to support with child care, most couples do not consider that in determining the number of children they want to have because, in most cases, they only receive social support from them. Couples take full responsibility for the financial cost that comes with raising children and thus social support received from the extended family did not come up as a factor that influenced family size.

With women increasingly participating in the labour force, both formal and informal, their domestic and reproductive roles are believed to interfere with their paid work. Women continue to play both roles in the family but in different ways. We identified

work-centred women, who limited the number of children to minimize its effect on their participation in the labour market. In such families, women spoke about the effect of combining domestic work and their job as well as the long breaks they had to take away from work whenever they conceived and delivered. Thus, with the 'contraceptive revolution' as stated by Hakim (2003), families can more easily determine the number of children they want to have. Aside couples controlling their family size using modern contraceptives, women sometimes took unilateral decisions and actions to control the number of children they have by enrolling in family planning programmes without the knowledge or consent of their spouses. Such acts could be linked to the availability of family planning methods that could be done in discreet as well as women's economic independence due to their participation on the labour market. Having children is determined by not only social and economic factors but also biological (health) factors such as infertility, which can influence the family size among couples. The gendered nature of society provides men the opportunity to determine their family size either by marrying additional wives or having a child with another woman. Thus, whereas among couples who have fertility issues husbands may have control over their desired family size, wives have less control on the number of children they prefer or desire. Overall, the changing family size among dual earner couples can be attributed to a combination of factors that are interrelated and interdependent.

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Résumé
La taille des familles au Ghana évolue de plus en plus, passant de familles nombreuses à des familles de petite taille en raison de la modernisation. Au fur et à mesure que les sociétés se modernisent, les couples commencent à limiter la taille de leur famille malgré la grande valeur que la société accorde aux enfants dans le mariage et la famille. Dans cette étude, nous explorons les facteurs qui influent sur le comportement reproductif des couples ghanéens à double revenu en mettant en évidence les opinions subjectives sur les facteurs qui influencent le nombre d'enfants qu'ils ont ou espèrent avoir en tant que couple. Une approche qualitative a été utilisée pour collecter et analyser les données. Les données ont été recueillies par le biais d'entretiens approfondis avec 47 couples à double revenu issus de communautés rurales et urbaines sélectionnées dans cinq régions du Ghana. Vingt entretiens avec des informateurs clés ont été menés avec des dirigeants communautaires afin de fournir le contexte social des zones d'étude. Les données ont fait l'objet d'une analyse thématique. L'étude a permis d'observer qu'il n'y avait pas de différences dans les facteurs influençant la taille des familles dans les communautés rurales et urbaines du Ghana. De plus, les résultats sont conformes aux études précédentes qui ont identifié des facteurs tels que le coût de l'éducation des enfants et la participation des femmes au marché du travail, bien que les significations et interprétations que les couples attribuent à ces facteurs aient légèrement changé. La taille de la famille des couples interrogés était influencée par la nécessité d'assurer une vie confortable à leurs enfants. L'accès aux contraceptifs modernes et l'infertilité ont également été cités comme des facteurs influençant la taille de la famille. Dans l'ensemble, l'évolution de la taille de la famille chez les couples à double revenu peut être attribuée à une combinaison de facteurs qui sont liés et interdépendants.

Mots-clés
couple à double revenu, genre, Ghana, santé reproductive, taille de la famille

Resumen
El tamaño de las familias en Ghana está evolucionado de manera acelerada desde familias grandes a pequeñas debido a la modernización. A medida que las sociedades se modernizan, las parejas comienzan a limitar el tamaño de su familia a pesar del alto valor que la sociedad otorga a los niños en el matrimonio y en la familia. En este trabajo, se exploran los factores que influyen en el comportamiento reproductivo de las parejas ghanesas de doble ingreso, poniendo el foco en las percepciones subjetivas sobre los factores que influyen en la cantidad de hijos que tienen o esperan tener como pareja. Se ha utilizado un enfoque cualitativo para recopilar y analizar los datos. Los datos se han recopilado a través de entrevistas en profundidad con cuarenta y siete parejas de doble ingreso en comunidades rurales y urbanas seleccionadas en cinco regiones de Ghana. Se han realizado también veinte entrevistas a informantes clave con líderes comunitarios para proporcionar el contexto social de las áreas de estudio. Los datos han sido analizados temáticamente. Se ha observado en el estudio que no hay diferencias en los factores que influyen en el tamaño de la familia en las comunidades rurales y urbanas de Ghana. Además, los hallazgos son consistentes con estudios previos que han

identificado factores como el coste de criar a los hijos y la participación de la mujer en la fuerza de trabajo aunque los significados e interpretaciones que las parejas atribuyen a estos factores han cambiado ligeramente. El tamaño de la familia de las parejas está influenciado por la necesidad de asegurar una vida cómoda para sus hijos. El acceso a anticonceptivos modernos y la infertilidad también han surgido como factores que influyen en el tamaño de la familia. En general, el cambio en el tamaño de la familia entre las parejas de doble ingreso puede atribuirse a una combinación de factores que están interrelacionados y son interdependientes.

Palabras clave
género, Ghana, pareja de doble ingreso, salud reproductiva, tamaño de familia