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Maternity protection and workers with family responsibilities in the formal and informal economy of Ghana. Practices, gaps and measures for improvement

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Preface

Following the Millennium Development Declaration, the 2030 Sustainable Development Agenda set out a number of goals aimed at ending poverty, ensuring healthy lives and well-being, achieving gender equality and women's economic empowerment, promoting decent work and reducing inequalities. Ghana played a major role at both national and international levels in defining the post-2015 development agenda and is committed to a development that 'leaves no one behind'. Ghana is often presented as a role model in Africa when it comes to democracy and socio-economic development. However, inequalities between regions and segments of population are still a challenge to improve the quality of life of the Ghanaian people.

With respect to women, in particular working mothers, the Government, in collaboration with workers' and employers' organizations and other national stakeholders, took up the challenge to improve the provision of maternity protection to women living both in rural and urban areas, as well as those working in formal small and medium sized enterprises (SMEs) and the informal economy. In order to assist Ghanaian constituents in this endeavour, the ILO commissioned a study from Middlesex University (United Kingdom) to provide an analysis of the legal, policy and regulatory framework of maternity protection and work-family policies, particularly for workers in SMEs and informal economy. Informed by the guidance of the ILO's Maternity Protection and Workers with Family Responsibilities instruments, as well as the ILO Social Protection Floors Recommendation, 2012 (No. 202) and the ILO Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), the study also identifies gaps and proposes policy and workplace improvements, taking into account the existing practices in Ghana and worldwide.

The report draws on 100 interviews with employers and workers around the country and was able to acknowledge the most common issues faced by working women and their families in combining a healthy pregnancy, childbirth, and the care of infants with decent work. The most prominent include: the lack of awareness of existing laws on maternity protection rights and benefits and family-friendly policies, the extension of paid maternity leave for informal and self-employed women based on the set up of social insurance-funded maternity cash benefits, the improvement of non-contributory schemes, the increase of transport connections in rural areas and the expansion and improvement of the maternal and child health care system.

Social and economic benefits arise from the improvement of these policies. Research shows that health for mothers and babies and gender equality could be boosted by adequate maternity and family-friendly policies. Moreover, for firms, reduction in absenteeism, increasing retention and loyalty not only increase productivity, but also reduce costs, such as recruitment and training costs.

This report is a prime source for understanding maternity policies and practices, as well as work-family balance in Ghana, and we hope that its findings and recommendations would guide policy makers in the design, improvement and evaluation of current legal and policy frameworks. Furthermore, the working paper presents ideas for further research on topics regarding improvements on maternity protection policies and practices, the feasibility and outcomes of different maternity supports in different types of workplaces, as well as of related social protection initiatives, to ensure improved access to income security and healthcare for mothers and children in Ghana.

This study builds on and expands the results of an ILO research report “Maternity protection in SMEs. An international review” (2014). It also contributes to the ILO’s objective of promoting the business-case as well as human rights-based justifications for shifting perceptions of improved social protection, work-life balance and, more broadly, workplace diversity policies from business costs to business investments, with returns that can be measured in improved productivity as well as better socio-economic outcomes and wellbeing, including in countries in the Global South and in the context of the informal economy.

We would like to thank the research team, both in the United Kingdom and Ghana, for this innovative and in-depth study on the topic, which will support changes in the Ghanaian policies regarding working women. The report has also benefitted from comments and contributions by a number of ILO experts, who enriched the final outcome of this work.

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Abbreviations

CHPS	Community-based Health Planning Service
CPIA	country's policies and institutional arrangements
GDP	gross domestic product
GHS	Ghana Health Service
GLSS	Ghana Living Standards Survey
GNSPS	Ghana National Social Protection Strategy
GSS	Ghana Statistical Service
ILC	International Labour Conference
ILO	International Labour Organization
LEAP	Livelihood Empowerment Against Poverty
LIPW	Labour Intensive Public Works Programme
MAF	MDG Acceleration Framework
MofGCSP	Ministry of Gender, Children and Social Protection
MP	maternity protection
NBSSI	National Board for Small Scale Industries
NDPC	National Development Planning Commission
NGO	non-governmental organization
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NSPP	National Social Protection Policy
NSPS	National Social Protection Strategy
SDG	Sustainable Development Goals
SME	small and medium sized enterprises
SPF	Social Protection Floors
SSNIT	Social Security National Insurance Trust
TBA	traditional birth attendant
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WFR	workers with family responsibilities
WHO	World Health Organization



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Executive summary

Introduction

This study explores the maternity protection practices and experiences of women workers in diverse communities in Ghana where there are high rates of maternal mortality and morbidity. It examines the current policy, legal and regulatory framework concerning maternity protection as well as the needs, concerns and practices with respect to maternity protection among employers and workers, including the self-employed. ILO Conventions and Recommendation set out the core elements of maternity protection which include: maternity leave, health protection at the workplace for pregnant and breastfeeding women, cash and medical benefits, employment protection and non-discrimination, as well as breastfeeding support after returning to work. They also lay out a number of work–family balance policies and practices at the workplace that aim at supporting workers with care responsibilities.¹ Other recent international labour standards recognize maternity protection as a right for all women: access to essential maternity health care and basic income security at a nationally defined minimum level should be guaranteed for all resident women in case of maternity.² Social security and maternity protection should be progressively extended, in law and in practice, to all workers in the informal economy and the provision of and access to childcare and other care services to promote gender equality and enable the transition to the formal economy should also be encouraged.³

Research on the impact of maternity protection on small firms is sparse and, in developing countries, it is virtually non-existent. Furthermore, there are dangers of evidence from larger organizations in developed countries being applied uncritically to developing countries, where the informal economy often dominates and enterprises are more influenced by their local communities and environment. In order to reflect the business landscape and women's situation in the labour market in Ghana, this study explores maternity protection policies and practices in both the formal and the informal economy in urban and rural areas.

Current maternity protection policies in Ghana

Ghana has ratified the ILO Maternity Protection Convention, 1952 (No. 103) and has national legislation providing 12 weeks paid maternity leave funded by the employer, although the majority of women do not receive this as they work in the informal economy. On returning to work, women are entitled to a daily one-hour break for breastfeeding. There is legal protection against dismissal when on maternity leave, but less protection during pregnancy. The labour law does make provision for allowing workers to change working patterns when there is a risk to health but there is no requirement to undertake a workplace risk assessment.

¹ See ILO Maternity Protection Convention, 2000 (No. 183) and the accompanying Maternity Protection Recommendation, 2000 (No. 191), the ILO Workers with Family Responsibilities Convention, 1981 (No.156) and the related Recommendation No. 165.

² See ILO Social Protection Floors Recommendation, 2012 (No. 202), para. 5.

³ The ILO Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), para. 18 and 21.

Ghana has not met the Millennium Development Goal (MDG) for reducing maternal mortality despite the MDG Acceleration Framework (MAF) Action Plan and policies providing antenatal care visits, births attended by health professionals and post-natal care. The Sustainable Development Goal 3 to “ensure healthy lives and promote well-being for all at all ages”, adopted in 2015, sets out new targets to be achieved by 2030, including to “reduce the global maternal mortality ratio to less than 70 per 100,000 live births” (Target 3.1) and to “end preventable deaths of newborns and under-five children” (Target 3.2). Women working in rural areas and in poorer regions are at greater health risk and there are reports that hypertension has overtaken hemorrhage as the leading cause of maternal deaths. Maternal health services are provided across Ghana, although the extent of access can vary. The National Health Insurance Scheme (NHIS) aims to provide more equitable health services with payment exemptions for pregnant and postpartum women and the very poorest. There are other programmes supporting the extreme poor such as Livelihood Empowerment Against Poverty (LEAP) which added pregnant women and mothers with infants (up to 15 months old) to its target groups in 2015. However, workers in rural areas face further constraints on accessing maternal health services due to poor transport infrastructure and lack of health facilities and qualified health professionals.

Methods

The study draws on 100 qualitative interviews with employers, self-employed and wage and salaried women workers, as well as with a range of stakeholders, including community groups, NGOs, researchers, policy makers and health workers across three geographic regions of Ghana. We take into account the considerable heterogeneity of types of employers and employees, depending, among others, on size of firm, industrial sector, level of formality, skill level, as well as the very different conditions faced by self-employed women and workers in remote rural areas. Social exchange perspectives are drawn on to explore how reciprocity within organizations shapes practices and entitlements. The study also focuses on the social relations that shape access to maternity protection, noting differences based upon subordination, discrimination and inequality.

Maternity protection challenges and unmet needs

The findings show that a distinction has to be made between larger employers, providing staff with contracts in line with the labour code, smaller employers who may be relying on informal contracts and the self-employed. While employers in the formal economy (both private and public) may offer longer maternity leave and other benefits, workers in the informal economy and self-employed are able to have greater flexibility in the workplace, allowing a change of roles and greater opportunities for breastfeeding and informal childcare arrangements. However, it is also important to highlight the challenges and constraints for those in the informal economy, including with respect to income security and access to health care. Without adequate maternity protection, this flexibility might thus end up in a “trap” for women in the informal economy. While they initially consider it a temporary coping strategy, women with children are likely to stay in the informal economy as they juggle breastfeeding, childcare and earning an income.⁴ The practices of maternity protection are shaped by the location of the workplace and have to be considered in the context of the extreme poverty experienced by many workers in smaller organizations and self-employed, particularly in rural areas where

⁴ See also research by Alfars (2016) on research findings on women informal workers and child care in five countries, including Ghana.

health services are sparse. It is notable that the majority of employers in the informal economy are women (GSS, 2014) and that the levels of maternity support they provide for their employees are often driven by their own vulnerability. Many workers (both salaried and self-employed) in the informal economy cannot afford to take time off from work, with important negative implications for their own health and that of their newborns.

Awareness of policy, legal and regulatory framework, and health issues. The interviewees (both employers and employees) reported a lack of awareness of maternity protection law. At times employers were not aware of their duties and only a few (larger) employers were proactively informing staff of their entitlements. This lack of awareness affected both employers and employees in negative ways. From the perspective of employers, not proactively informing staff of their rights in detail often resulted in employees not appreciating (sometimes costly) supports beyond legal entitlements. At the same time, employees in smaller workplaces, particularly in the informal economy, tended to regard any support they received as a favour, making them prone to exploitation and discrimination.

Gendered cultural norms, traditions and expectations. Lack of knowledge of legal entitlements also provides a context where cultural norms and expectations with respect to gender roles can largely remain unchallenged. Women's and men's roles as workers and parents influenced the nature and effectiveness of maternity protection practices across workplaces. Awareness is also an issue related to maternal health more generally, particularly for the self-employed. This includes cultural norms, gender roles and traditions that put pregnant women and their children at risk. The extent of unpaid household and care work of women can affect maternal health, with men's roles mostly discussed only in terms of financial support. Employers are not supporting men through family-friendly working practices, and cultural norms place further restrictions on men. There is thus a need to challenge deep-seated gendered assumptions and stereotypical thinking that underpins notions of "ideal workers" that preclude maternity and "ideal carers" that preclude paternity. However, interviews in Accra show that the cultural norms are changing amongst some groups.

Workplace culture and the business case for maternity protection. While some businesses had a culture of not giving support, others particularly in the informal economy were found to reward loyalty of staff with better maternity protection. Many businesses were found to stop employing women when they became pregnant, or did not want to provide support during pregnancy and after return to work. In the formal economy, maternity leave was provided in line with legal requirements, but other support from senior staff/line managers and other colleagues was lacking. By exploring the types of costs and benefits of maternity protection, this study identifies those employers who recognize the benefits in terms of providing a family-friendly workplace, including high-retention rates, increased staff co-operation, reduced absenteeism, as well as improved motivation and performance. Trust between employers and employees, as well as between colleagues was found to be very important, and could result in greater support. However, such support was at the discretion of the employer and often provided on a one-to-one basis.

Self-employment and livelihoods. The self-employed in the informal economy have the least protection, particularly women with the lowest income. Living in poverty means that these women are more likely to have less robust health to start with, e.g. suffering from anemia or malnourishment. At the same time, they face greater barriers to access health care: they

struggle to afford time off for antenatal checks or take time off work before and after birth. Poverty also shapes their ability to pay for transport and additional healthcare costs before, during and after childbirth. This results in women not attending clinics, giving birth at home without any medical care, and not taking maternity leave. One participant stated “*out of necessity we close our eyes*”. Poverty also limits access to childcare, with some families withdrawing their older children from school to look after their younger siblings, if they could not ask other relatives to help with childcare.

Rural workers and access to health. Women working and living in rural areas face particular challenges in accessing healthcare and registering for National Health Insurance. Interviewees reported walking up to 10 km from work or home to attend clinics or to register. They also had to take days off work due to the distance and delays, with some even walking to clinics the night before in order to be seen. Experience of a miscarriage in a previous pregnancy, or hearing from other women who had suffered a miscarriage as a result of these exhausting walks further discouraged women from attending antenatal checks, particularly when closer to giving birth.

Further delays were reported when women (particularly those working in agriculture) had to walk to their homes from distant farms, had to wait for their husbands to give them permission to leave the community and then wait for transport to arrive. In some rural villages, motorized tricycles had been provided by the Government to help with transport to hospitals, but the driver would often not answer the phone, especially during the night, or the tricycle would not be fuelled when needed. In terms of emergency transport, the taxi service was the only option for most, with some women working in rural areas having to walk long distances to get to motorable roads, or even rely on bicycles.

Lack of awareness regarding danger signs during pregnancy, labour or on how to plan for a skilled delivery especially among the poor and rural population represent additional barriers to access health facilities.

Box. 1: Examples of good practices and coping strategies

Health protection in the workplace

Ante- and postnatal visits

1. Giving employees paid time off to attend antenatal check-ups ^{1,2,3,4}
2. Informing employees and self-employed workers of the importance of antenatal visits to allow identification of complications early on ^{1,2,3,4}
3. Overcoming transport barriers in remote rural areas ^{3,4}
4. Promoting and facilitating registration with the NHS ^{1,3}

Changing workload and type of tasks

5. Re-arranging the workload of staff during pregnancy ^{1,2,3,4}

Maternity/paternity leave and cash benefits

6. Paid maternity and paternity leave in formal economy ^{1,4}
7. Maternity leave with pay in informal economy ^{2,3,4}
8. Affordable maternity absence management ^{1,2,3}
9. Mutual support (cash and kind) through associations ^{2,3,4}

Employment protection and non-discrimination

10. Guaranteeing the right to return to the same position ^{1,2,3,4}
11. Recognising the need for equal opportunities and treatment at the workplace ^{1,2}

Breastfeeding

12. Paid breastfeeding breaks that work for the employee ^{1,2,3}
13. Giving mothers the opportunity to regularly bring infants to work and providing supportive environments for women to breastfeed ^{1,2,3,4}

Childcare

14. Formal childcare support ^{1,2,3}
15. Informal childcare support ^{2,3,4}
16. Making use of under-/unused community asset ^{3,4}

Flexible and family-friendly working arrangements

17. Changing hours of work upon return (e.g. allowing to work part-time; flexible hours) ^{1,2,3}
18. Allowing workers with family responsibilities to work from home if possible ¹

*Practices identified in large businesses ⁽¹⁾; SMEs ⁽²⁾; the informal economy ⁽³⁾; rural areas ⁽⁴⁾

Recommendations

The conclusions draw out the gaps in provisions and existing helpful practices that aim to tackle issues relating to the health and income security of mothers and their families as well as the sustainability of businesses. The following recommendations are made:

Awareness of the policy, legal and regulatory framework on maternity protection

Recommendation 1. It is recommended that specific campaigns for raising awareness of the policy, legal and regulatory framework are developed for each segment (large employers, small businesses, self-employed and wage and salaried workers in both the formal and informal economy), ensuring that the approach is targeted and appropriate. Traditional leaflets and posters are less likely to be successful (particularly in light of low literacy rates among some parts of the population) than more innovative use of a range of existing types of media, events at schools and business associations.

Recommendation 2. Extending paid maternity leave to uncovered women is only possible if the Government is able to cover some of the costs through the establishment of a contributory social insurance scheme funding maternity benefits, direct payments or tax relief and incentives. For employers and workers in the formal economy, a feasibility study could be carried out to explore financing options for incorporating maternity cash in the Social Security National Insurance Trust (SSNIT). It is recognised that this may be unlikely in the current context. Employers report that they struggle to afford existing financial support, so an increase in the length of paid maternity leave without a social insurance scheme covering maternity cash benefits is likely to lead to greater discrimination in recruitment of women of childbearing age. In addition, guaranteeing income security for women in the informal economy should also be among the priorities, for instance through the improvement of the coverage and sustainability of the LEAP programme and/or the inclusion of maternity protection in public works programmes.

Recommendation 3. Maternity leave is more likely to be granted if the business can find efficient and cost-effective cover. This is found, for instance, when the workload is reorganized by spreading work tasks among colleagues and hiring fixed-term workers (including apprentices and interns). There is also a need to demonstrate and promote the business case for staff retention through maternity protection.

Health protection at work

Recommendation 4. In order to ensure that the health of pregnant or breastfeeding workers and their child is not put at risk, there is a need to identify any potentially dangerous work or harmful working conditions, eliminate the risk, adapt the working conditions or, if the latter options are not possible, to temporarily transfer women workers to another kind of work not prejudicial to their health without loss of wages.

Recommendation 5. The greatest risks of maternal mortality and morbidity are found amongst the self-employed with low income who are not able to afford time off and/or direct costs for antenatal check-ups, skilled delivery, maternity leave or childcare and cannot cover transport costs.

Supporting women's livelihoods and enterprises and ensuring the self-employed have access to health services is therefore crucial for maternity protection as well as economic development.

Recommendation 6. Health protection in the workplace for the self-employed requires specific awareness programmes which can also include the importance of health insurance. These can be focused on chiefs, "queen mothers" (traditional community midwives), leaders of associations and community groups, elders, head teachers, parent teacher associations, churches and mosques. The use of mobile cinema vans and stage play in remote and rural areas is one concept that can be explored due to its high success in awareness creation in such communities.

Recommendation 7. Mobile antenatal care for rural self-employed and employees, similar to models of monthly baby clinics, can help identify complications early, and reduce the costs of transport and time off work. These can use existing community facilities on a monthly basis but would require funding for the fuel and transport costs of nurses and midwives. NHIS registration could become available online or by phone to reduce waiting times at facilities. In order to also include those with limited internet or phone access and illiterates, registration could be made available during mobile antenatal and baby clinics.

Cash and medical benefits

Recommendation 8. The poorest self-employed people such as those benefiting from the LEAP programme should be entitled to benefits (in addition to current LEAP payments) to help them cover the costs of lost work and transport to health service. Increased efforts are also needed to extend LEAP coverage to all of the extreme poor, and to use a system of direct payments to reduce current issues with timely payments to recipients.

Recommendation 9. Opportunities for vouchers for taxi or other commercial vehicle fares (to and from antenatal care and during labour/after giving birth) could be explored for women with very low or no income, such as those involved in the LEAP programme. This also requires first aid and providing emergency transport for the sick by ambulances, and to ensure taxi drivers are not penalised for bringing women to health services who do not have the means to pay for health services.

Supportive workplaces

Recommendation 10. Training programmes on good practice in managing maternity protection and workers with family responsibilities should be included in the extra courses related to leadership and entrepreneurship currently being delivered or planned in schools, colleges and universities. Examples include short courses for all students as future leaders of businesses (large and small), on starting and managing businesses, and on growing businesses which should provide a basic understanding of the need for maternity protection and family-friendly measures at the workplace.

Recommendation 11. All employers, especially those in formal businesses and the public sector should be encouraged to provide more support to mothers with codes of conduct supporting breastfeeding, and maternity-friendly spaces provided for breastfeeding and related

working time arrangements. Employers should also be informed of the benefits (for both their business and their workforce) of establishing a workplace culture which encourages mutual supports between colleagues.

Recommendation 12. Improved access to childcare at or close to the workplace, teleworking arrangements and other support measures can assist breastfeeding and work-family reconciliation, allow staff to work more productively and help women stay in the labour market. Provision of accessible, adequate and affordable public childcare services and pre-primary education should be a priority. Support to private and social enterprise nurseries can come through specific training programmes and financial support that encourages childcare enterprises or cooperatives offering quality and affordable services to be set up and grow. Childcare can be supported through better use of existing community spaces and facilities such as community centres, town councils and churches. Several small employers in the same geographic location can get together in providing affordable and practical childcare solutions or, alternatively, be given access to the childcare provisions of larger employers.



1. Introduction

This report explores the maternity protection practices and experiences of working women in Ghana, including maternity leave, cash and medical benefits, employment protection and non-discrimination, besides health protection and support measures at the workplace for pregnant and breastfeeding women. It also covers a number of work–family balance policies and practices in the workplace, which are also part of the continuum of care measures enabling return to work after leave as well as permanence and progress in economic activity.¹

Existing literature on the effects of maternity protection on small firms is scarce, especially in developing countries.² Therefore, there is a need to develop context-specific research in order to avoid implementation of maternity protection policies based on evidence from either developed countries or large organizations, particularly since most economies in the developing world are dominated by the informal economy, rural activity and small and medium sized enterprises (SMEs). By trying to properly address the business environment and women's situation in the labour market in Ghana, this study acknowledges the formal economy and large enterprises in the country, but will mostly focus on maternity protection in SMEs, informal economy and rural areas and present the results of a qualitative field study carried out in 2014.

1.1 Study objectives

In consultation with the Government of Ghana, the study covers the following aspects:

- Review of the existing policy, legal and regulatory framework governing maternity protection in Ghana with respect to the Maternity Protection Conventions, 1952 (No. 103) and 2000 (No. 183), the Workers with Family Responsibilities Convention, 1981 (No. 156) and their corresponding Recommendations as well as the Social Protection Floors Recommendation, 2012 (No. 202).
- Identification of gaps in the current framework, including data and research gaps, and proposed measures to be addressed, with a particular focus on women of childbearing age in formal small and medium sized enterprises (SMEs), the informal economy and working in rural areas.

¹ See ILO Maternity Protection Convention, 2000 (No. 183) and the accompanying Maternity Protection Recommendation, 2000 (No. 191), the ILO Workers with Family Responsibilities Convention, 1981 (No. 156) and the related Recommendation No. 165.

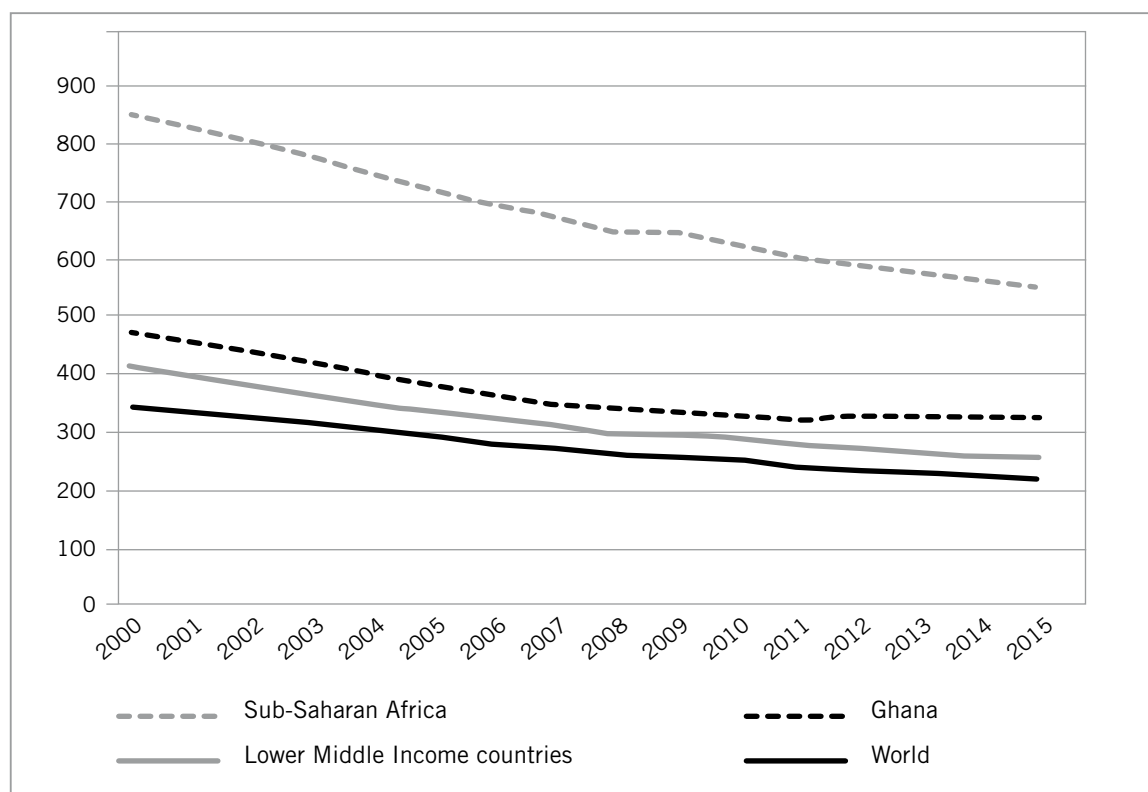
² Lewis, S., Stumbitz, B., Miles, L., Rouse, J. 2014. *Maternity protection in SMEs: an international review*. International Labour Office: Geneva.

- Identification of issues related to the effective implementation of maternity protection and support to workers with family responsibilities, with focus on workers in SMEs, informal economy and selected rural areas.
- Identification and documentation of employers' and workers' practices, concerns and needs related to actual implementation of adequate maternity protection and supports to workers with family responsibilities.
- Highlighting of direct and indirect costs and benefits of these measures in different workplaces, as perceived or documented by key informants as well as workers (both women and men) and employers.
- Identification of replicable and scalable national and local good practices covering employers and workers in both formal and informal workplaces, SMEs and rural areas.
- Through key informants as well as workers (both women and men) and employers, documentation of views from different workplaces as to how to address these issues, improve coverage and effective implementation of maternity protection and support to workers with family responsibilities, with a view to inform policy and legal choices.

1.2 The challenge of maternity protection, health and SDGs in Ghana

Maternity protection and advances in gender equality are crucial for sustainable development as framed by the 2030 Sustainable Development Agenda adopted by 193 UN Member States in September 2015. Specifically, maternity protection contributes to the achievement of Sustainable Development Goals (SDG) 1 to end poverty in all its forms everywhere; SDG 3 on healthy lives, including reproductive, maternal and child health; and SDG 5 on gender equality and empowerment of women and girls. International commitment on the SDGs builds on the outcomes of the previous Millennium Development Goal (MDG) 3 on gender equality promotion and women empowerment, and MDG 5 on the improvement of maternal health. With respect to the MDG 3, although disparities are still high, the majority of countries reached primary education gender parity, including two-thirds of developing countries (UN, 2015: 28). For MDG 5, maternity mortality ratio was halved between 1990 and 2015, but, in developing countries, only half of pregnant women have access to four visits to pre-natal care, as recommended (*ibid*: 38). ILO estimates also suggest that over 800 million women workers are lacking income security as a result of maternity (ILO, 2014a).

In Ghana, the implementation of the MDGs was boosted by the adoption of the MDG Acceleration Framework (MAF) Action Plan – a specific United Nations (UN) system program that supported eleven countries (in Africa it targeted Ghana, Tanzania, Togo and Uganda) to accelerate the implementation of the MDG 5 target of reducing maternal mortality by three quarters by 2015. In fact, in 2011 it was acknowledged that the maternal mortality target was off track (UNDP, 2011: 18). The MAF aimed to address identified challenges impeding the achievement of MDG 5 and had as objectives to review existing policies in maternal health care, identify bottlenecks and gaps for those policies' implementation, develop cost-effective solutions to accelerate the achievement of MDG 5, and design an action plan for implementing policies and monitoring progress (*ibid*). However, in Sub-Saharan Africa, maternal health

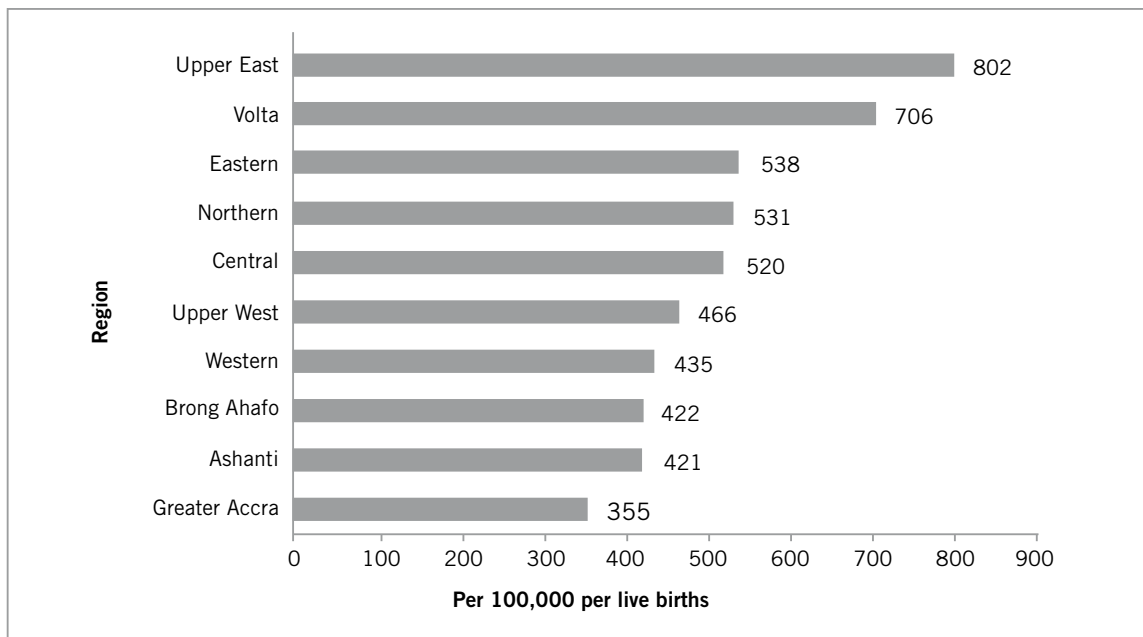
Figure 1.1: Maternal mortality ratio (modelled estimate, per 100,000 live births), 2000 – 2015

Source: World Bank – World Development Indicators.

and socio-economic development remain strongly linked (Mensah, 2009a), and the improvement of maternal health (MDG 5) was not within the target by 2015, although there was a reduction of 49 percent from 1990 to 2015 in the Sub-Saharan region (UN, 2015). This overall development is also reflected in the case of Ghana. The maternal mortality rate was 319 per 100,000 live births in 2015, and therefore failed to meet the MDG target of 185 per 100,000 live births.³ Figure 1.1 compares this indicator among Ghana, Sub-Saharan Africa, Lower Middle Income Countries and the World.

However, it has to be recognised that maternal health outcomes in Ghana also differ between regions (see Figure 1.2), urban and rural areas, types of work, socio-economic, and ethnic groups, as well as related cultural norms, traditions and expectations (Mensah and Oppong, 2009). Maternal mortality is slightly higher in rural areas. However, as Figure 1.2 shows, the disparities between regions are much more profound (GSS, 2013a). The majority of maternal

³ However, “maternal mortality is difficult to measure because it requires information about deaths among women of reproductive age, pregnancy status at or near the time of death, and the medical cause of death. All three components can be difficult to measure accurately, particularly in absence of a comprehensive vital registration system or accurate medical certification of cause of death. Consequently, all existing estimates of maternal mortality have varying degrees of uncertainty” (Mensah and Oppong, 2009: 8).

Figure 1.2: Maternal mortality ratio by region

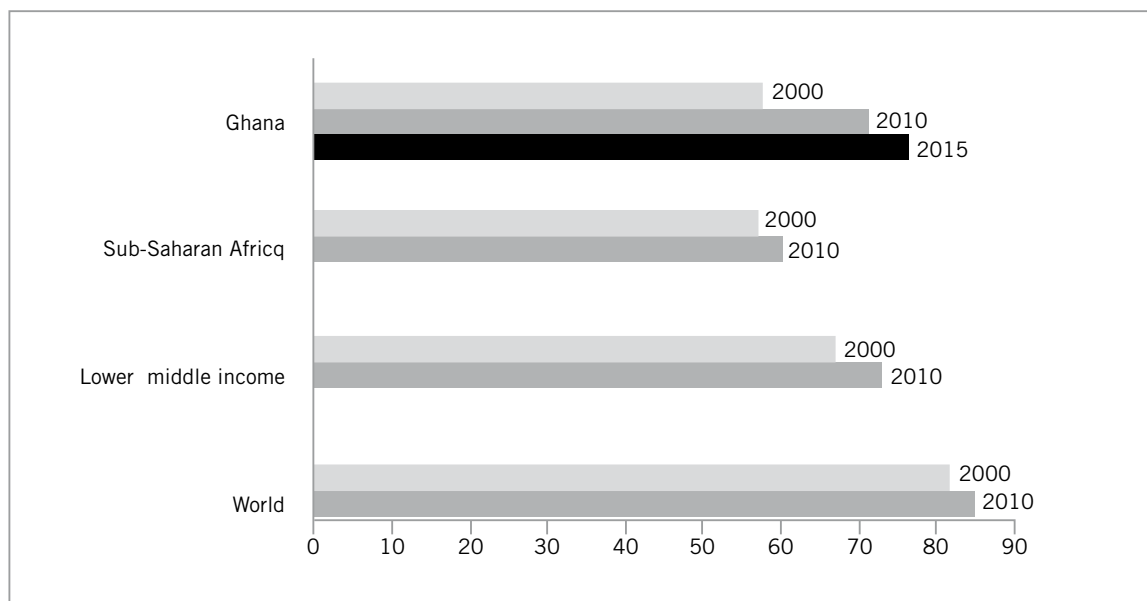
Source: Ghana Statistical Service (2013a: 36).

deaths⁴ result from a combination of biological, medical, and social factors, which are often inextricably linked (Babinard and Roberts, 2006; Bhutta 2005; Steklenburg et al. 2004).

In response to this realization and the absence of significant progress over the years, the ILO developed a project entitled “Building a Social Protection Floor for Pregnant Women and Nursing Mothers in Ghana”, with the aim of strengthening the organization’s contribution to the MAF in Ghana. The project aims at building a floor of social protection for pregnant women and breastfeeding mothers through improving access to health care and livelihoods. This includes ensuring safety for women in their ‘workplaces’ (access to maternal health care, including prevention of vertical transmission of HIV, access to maternal health issues and maternity protection), with a particular focus on low-income pregnant and breastfeeding workers in small firms in rural areas and in the informal economy.

Ghana is often presented as a role model within Africa, particularly with respect to aspects such as its democratic structure, economic performance and well educated population, although this development has not reached all regions and segments of the population evenly (Danish Trade Union Council for International Development Cooperation, 2014). Poverty remains a pervasive issue; some have no education at all and live as subsistence farmers (Jones et al., 2009). For instance, from 2000 to 2010, Ghana’s adult literacy rate increased from 57.9 per cent to 71.5 per cent. This was an outstanding result, given that in Sub-

⁴ Maternal death is defined as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes” (WHO, 2014: 4). So-called *direct maternal deaths* result from “conditions or complications, or the management thereof, which are unique to pregnancy and occur during the antenatal, intrapartum, or postpartum period. In a study of causes of maternal death in a tertiary hospital in Ghana, hypertensive disorders were found to be the most common direct cause (31.7 per cent), followed by obstetric haemorrhage (26.6 per cent), unsafe abortion (11.1 per cent), and puerperal sepsis (3.5 per cent) (Adu-Bonsaffoh et al., 2013).

Figure 1.3: Adult literacy rate, population 15+ years, both sexes (%)

Source: World Bank – World Development Indicators.

Saharan Africa overall, adult literacy had increased from 57.0 per cent to only 60.36 per cent in the same period. However, if considering other lower middle income countries and the world average, the Ghanaian illiteracy ratio is still quite high. Within the country, the three northern regions (Northern region, Upper East and Upper West) “harbour the poorest of the poor” (UNDP, 2007: 151) and often lack the most basic amenities required for a satisfactory standard of living, such as portable water, decent roads and schools (Osei-Boateng, 2011).

As regards MDG 3 on gender equality, there has been significant progress in some respects, although the country also failed to achieve this goal. For instance, gender parity in kindergarten was achieved in the country and there was an increase from 25.4 per cent in 2006 to 30.5 per cent in 2013 in women’s access to wage employment in non-agricultural sectors (UNDP, 2015: 10). However, in Ghana, as in many other countries, a history of deeply rooted patriarchal gender relations places women in a position subordinate to men, as reflected in women’s higher rates of involvement in low skill, low wage work in the informal economy, often under the absence of the most basic social protection (Tessier et al., 2013; UNDP, 2007). All of these conditions contribute to women’s particular vulnerability to poverty and social exclusion, and also to persisting high rates of maternal mortality. In order to systematically address the target of SDG 3 (ensure healthy lives and promote well-being for all at all ages), there is a need to explore the underlying (and often overlapping) factors which provide the key barriers to reducing maternal mortality and improving women’s livelihoods.

Key factors with respect to maternal health outcomes include access to and take-up of antenatal care, the presence of skilled attendants at birth;⁵ timely access to quality emergency

⁵ As Mensah and Oppong (2009: 10) point out, a major challenge lies in determining who counts as a skilled attendant: “While efforts have been made to standardize the definitions of doctors, nurses, midwives and auxiliary midwives used in [...] surveys, many attendants who are described as “skilled” would probably not meet the internationally accepted criteria (WHO 2004)”.

obstetric care and, more generally, access to education and improved awareness regarding maternal health (Holmes and Kennedy, 2010; Mensah and Oppong, 2009). This study focuses on maternity protection measures at the workplace which have been identified as another important factor. For instance, some evidence indicates that stressful working conditions may be responsible for the development of pregnancy-induced hypertension among pregnant women in urban areas in Ghana (van Middendorp et al., 2013). The disease has also overtaken haemorrhage as the leading cause of maternal deaths in the country (Adu-Bonsaffoh et al., 2013, 2014, 2017; GHS, 2010; Lee et al., 2012). Pregnancy induced hypertension could be due to a pre-existing hypertension disease in the woman before she became pregnant, but it could also be attributed to the changing lifestyles of pregnant women where they are predisposed to stressful conditions and have little rest.

1.3 The importance of maternity protection in the workplace

An analysis of maternity protection at work in Ghana requires a deeper understanding of female employment as well as attention to the characteristics of work arrangements and the wider environment in which they are embedded. The workplace can take very different forms, including office settings, market places, as well as farms and communities/villages for many rural/farm workers, and the household for domestic workers.

In Ghana, labour force participation of women has increased and become more balanced (49.7 per cent), much ahead of the rest of the world, as we can see in Figure 1.4. However, women (10.6 per cent) are still considerably less likely to be in paid employment than men (24.6 per cent) and more likely to be self-employed without employees (50.2 per cent) than men (44.6 per cent).⁶ In addition, 29 per cent of women work as (often unpaid) family workers in comparison to 17.9 per cent of men. Women's labour market participation is influenced by a number of factors (e.g. demographic, cultural, socio-economic, life-course).⁷ Ghanaian women also bear the overwhelming responsibility for unpaid work, such as housework, or care-giving for children and other dependents (such as older relatives or relatives with disabilities) (Clark, 1994; Hampel-Milagrosa, 2011; Kabeer, 2012; Tessier et al., 2013).

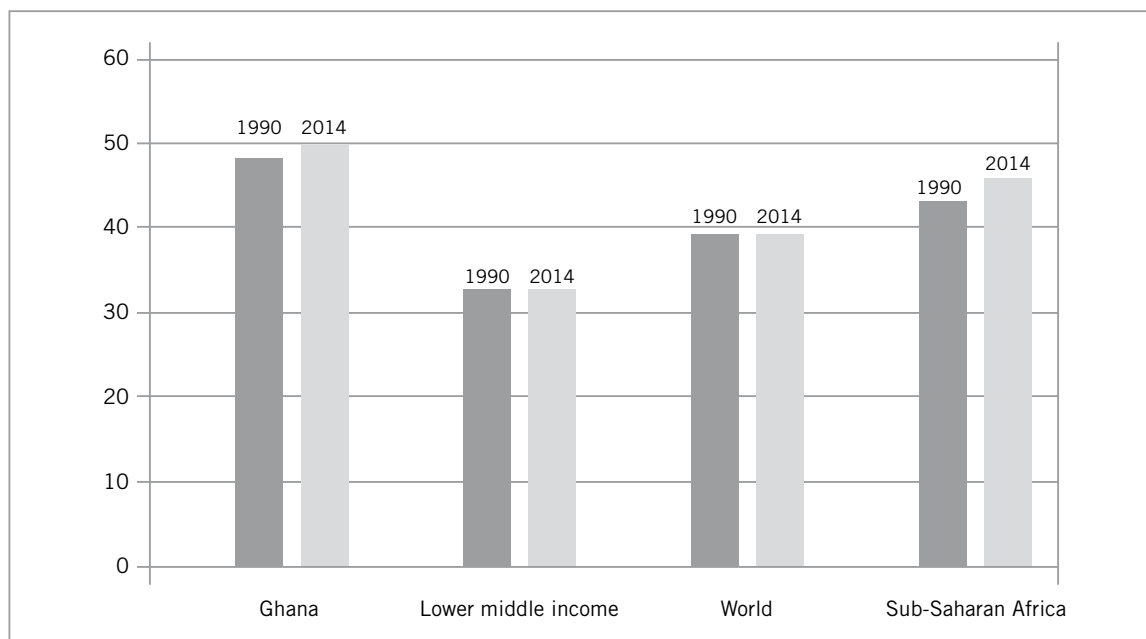
As in most African countries,⁸ SMEs⁹ are also an important feature of the Ghanaian economy, representing about 99.6 per cent of businesses in Ghana in 2014, with some variations between sectors, whereas less than 0.5 per cent are large enterprises (GSS, 2015). In the industry sector, SMEs represent 99.5 per cent of firms, while in the service sectors, they constitute 99.6 per cent of total establishments (*ibid*: 31-36). In agriculture, SMEs represent a smaller – but still very significant – percentage of 96.7 per cent. In Ghana, the majority of

⁶ Men (6.9%) are slightly more likely to employ staff than women (5.1%) (GSS, 2013a).

⁷ For instance, Ewe and Akan women are more likely to work than other ethnic groups and less wealthy women (indicated by the number of assets in the household) are more likely to be economically active.

⁸ SMEs account for over 90% of private businesses and contribute to more than 50% of employment and of GDP in most African countries (Abor and Quartey, 2010).

⁹ There is no universally agreed definition of SMEs in Ghana and the most frequently used definition is the number of employees of the enterprise (Abor and Quartey, 2010). Our categorisation corresponds with that used by the Ghana Statistical Service (GSS, 2015) in their recent Integrated Business Establishment Survey: micro (1-5 staff); small (6-29 staff); medium (30-100 staff), large (100+ staff).

Figure 1.4: Labour force participation, female (% of total labour force), 1990 and 2014

Source: World Bank – World Development Indicators (2016).

SMEs are micro (with up to five staff) and constitute 80 per cent of all firms. Of those, only few small firms make the transition into mid-range size (sometimes referred to as the ‘missing middle’) (Sleuwaegen and Goedhuys 2002). In addition, most small firms are one-person businesses and the largest employment category is therefore self-employment. However, given the prevalence of the informal economy in Ghana, the majority of SMEs here are not considered in official statistics, and this is particularly true for female-owned businesses (Abor and Quartey, 2010).

A large proportion of women in Ghana work in informal labour markets¹⁰ and beyond the reach of regulation (GSS, 2014). It is estimated that 90.5 per cent of Ghanaian labour force work in the informal economy (GSS, 2015). The formal economy already has certain established maternity protection systems in place which provide a basis for exploring what the informal economy may be missing. There is no clear boundary between the two, but this study will examine the specific characteristics of both formal and informal businesses in Ghana, recognising that models of ‘ideal type’ enterprises modelled on a European or North American context are not appropriate, since labour market characteristics are very distinct. For instance, there is a long history of successful enterprise in Ghana with a range of different forms and important roles of associations in shaping the informal economy and those should be taken into account when designing maternity protection policies. Local cultural context also shapes the nature of the firm or employer as well as maternity protection issues (Hill et al., 2014). The recognition of diversity will need to consider the sectorial differences, the locational differences (urban/rural, regional, also with respect to areas with high poverty and/or maternal mortality), the ethnic differences, and the differences in size of enterprises.

¹⁰ See Appendix II on characteristics of the informal economy.

A recent review of maternity protection in SMEs (Lewis et al., 2014) argues that effective maternity protection in the workplace together with family supportive practices can impact on a range of positive social outcomes including not only reproductive health but also contributing to poverty reduction, gender equality and economic development. Furthermore, supportive practices can ultimately enhance human capital and translate into positive outcomes for firms, although this is rarely researched in low income countries. In Ghana, for example, research directly relevant to maternity protection in SMEs is currently very limited. Given the importance of successful business cases as an incentive to SME employers to develop effective and accessible maternity related practices and policies, more and better research is needed to build an evidence base for this argument, also in relation to the informal economy and rural employment. In this respect, the study by Lewis et al. (2014) is an important benchmark for the future implementation of maternity protection policies in other SMEs. It identifies emerging evidence that the typical characteristics of informality and flexibility in SMEs can facilitate the use of no or low cost maternity protection measures, such as workplace breastfeeding support, informal childcare support and flexible working time arrangements, and can lead to and sustain positive firm level outcomes. It is also vital that women have access to pre- and post-natal health care and have a sense of entitlement to be able to actually take up this care while also continuing to work for their livelihoods. This is crucial for the health of mothers and their babies and has significant economic implications. These examples of positive practices could therefore be used as incentives to adopt workplace support measures for maternity and families, which can be used to build up and strengthen national policies.

This research paper therefore aims to provide in-depth multiple perspectives on maternity protection in a low-income setting, including the needs and concerns of employers, workers, providers of maternal health care in the existing health care system and other stakeholders. It can encourage a holistic understanding of gaps in provisions and helpful practices, within the specific regulatory and policy context. The aim is also to encourage dialogue and collaborative and participatory approaches to issues relating to health and income security of mothers and their families, as well as the sustainability of businesses.

1.4 Structure of the review

We begin by an analysis of the existing policy, legal and regulatory framework governing maternity protection provisions at work as well as recent social protection initiatives in Ghana. This is followed by the methodology chapter, which introduces the theoretical approaches underlying this study as well as the methods used. We then present our empirical data on current maternity protection practices, challenges and unmet needs, identifying five key themes shaping women's experiences of work during pregnancy and early motherhood (awareness of maternity protection; gendered cultural norms, traditions and expectations; workplace culture and reciprocity; livelihoods and self-employment; and access to health services for rural workers), as well as a number of well-documented workplace good practices. The final section concludes and provides recommendations for policy intervention and future research.

2. Analysis of the policy, legal and regulatory framework governing maternity protection at work in Ghana

This chapter analyses the existing policy, legal and regulatory framework and current practices in relation to maternity protection at work, who has access to these supports in practice and gaps in provision. The first part examines maternity protection provisions as stipulated by current labour law. However, although in theory Ghana's labour law applies to all workers (apart from some exceptions¹), related statutory provisions are linked to formal employment as implementation in the informal economy is very limited. Consequently, the majority of women workers in the Ghanaian economy are not covered by these. The second section therefore reviews recent social protection initiatives that include maternity support measures and aim to reach all workers, including those operating in the informal economy. The last section draws attention to the special maternity protection needs of women working in remote rural areas.

2.1 ILO Maternity Protection Conventions and current provisions and gaps in Ghana

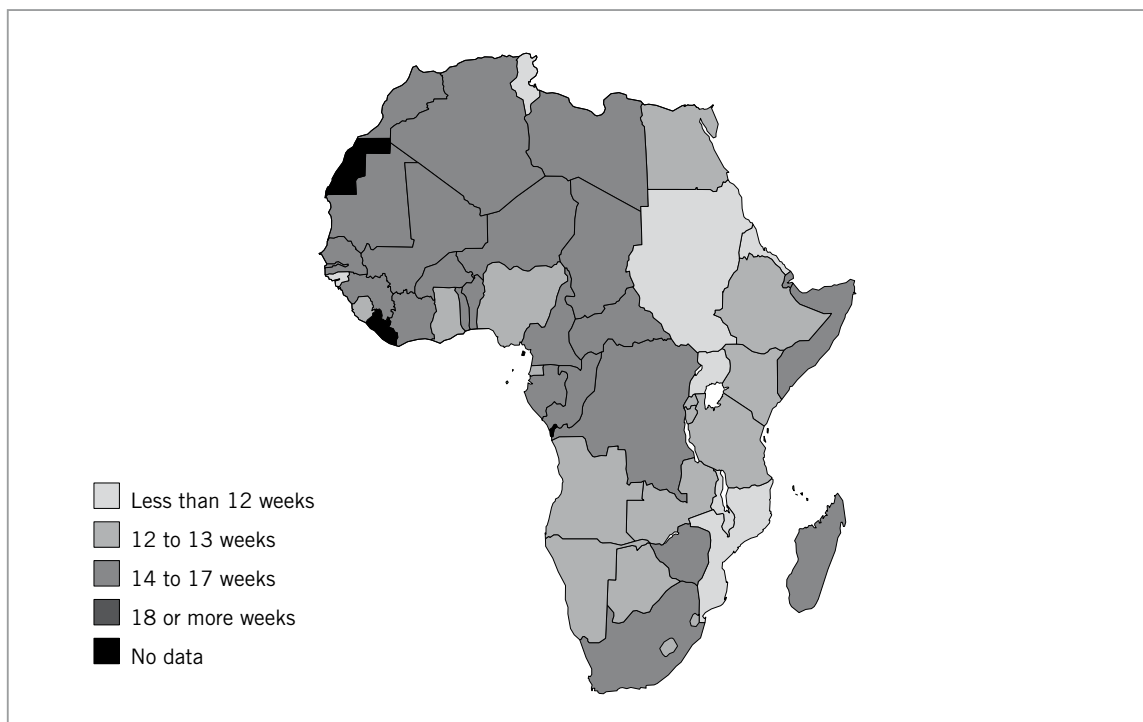
2.1.1 *The existing policy, legal and regulatory framework*

Over the years, three ILO Conventions on maternity protection (No. 3, 1919; No. 103, 1952; No. 183, 2000), in combination with their related Recommendations (No. 95, 1952; No. 191, 2000), have gradually extended the scope and entitlements of maternity protection at work and provided guidance for member States on how to translate these principles and rights into policy and action (ILO, 2012a).² According to the ILO Maternity Protection Convention, 2000 (No. 183), maternity protection provisions cover the following main aspects: maternity leave and leave in case of illness or complications, cash and medical benefits, health protection in the workplace, employment protection and non-discrimination, and breastfeeding arrangements. In addition, the ILO Workers with Family Responsibilities Convention No. 156 also provides for family-friendly working conditions, labour force reintegration measures, childcare and other family services and facilities, social security benefits, measures to reduce unpaid care work through basic infrastructure and labour-saving devices, and education and awareness-raising to promote equality of opportunity and treatment and non-discrimination.³

¹ The Labour Act 651 (2003) applies to all workers and to all employers except the Armed Forces, the Police Service, the Prison Service and the Security and Intelligence Agencies specified under the Security and Intelligence Agencies Act 1996 (Act 526). "Worker" means a person employed under a contract of employment whether on a continuous, part-time, temporary or casual basis.

² Conventions are binding treaties for those Member States who voluntarily ratify them. They are complemented by Recommendations that provide guidance to Member States but are not legally binding: <http://ilo.org/global/standards/introduction-to-international-labour-standards/conventions-and-recommendations/lang--en/index.htm> [Accessed July 2017].

³ See also the ILO Maternity Protection Resource Package, available at: <http://mprp.ilo.org/pages/en/index.html> [Accessed July 2017].

Figure 2.1: Duration of maternity leave (in weeks), 2016

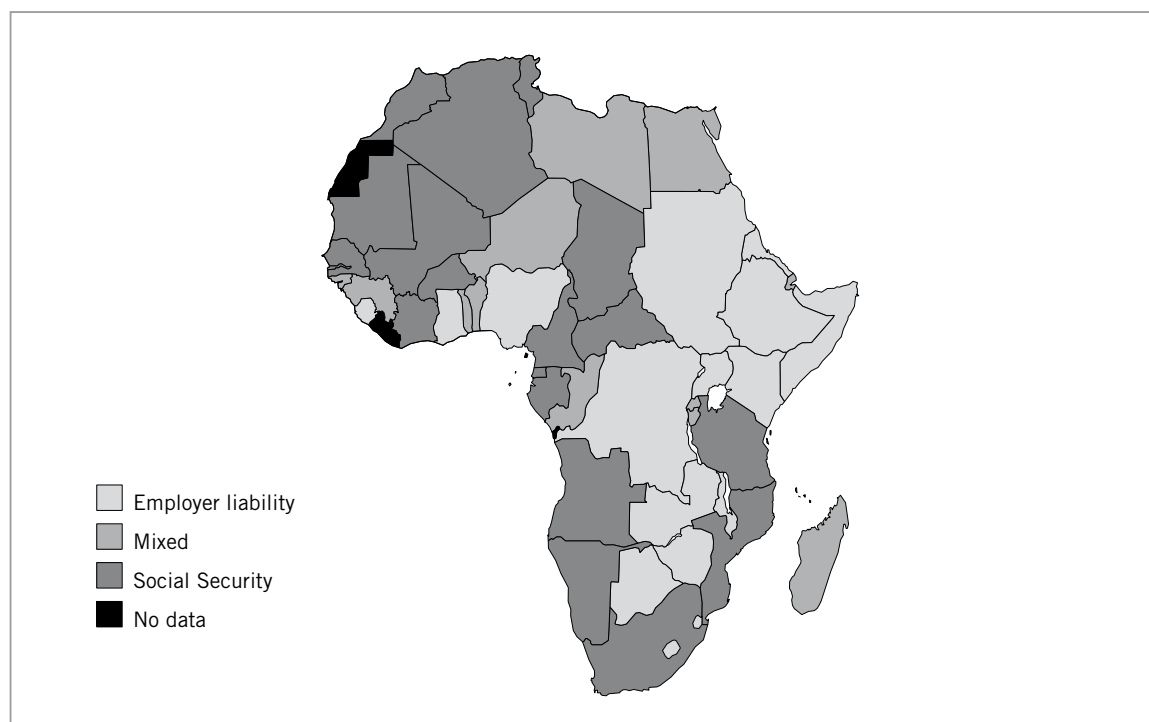
Source: ILO Conditions of Work and Equality Department.

The nature of maternity protection provisions varies widely across national contexts and regions (see Addati et al., 2014 for an overview).

As of December 2016, worldwide, 24 countries have ratified the Maternity Protection Convention, 1952 (No. 103), among which only three countries (Equatorial Guinea, Ghana and Zambia) were from the Sub-Saharan region. Convention No. 183 achieved 32 ratifications, including three from Sub-Saharan countries (Benin, Burkina Faso and Mali). With respect to the Workers with Family Responsibility Convention, 1981 (No. 156), 44 countries have it currently in force, among which four from Sub-Saharan Africa (Ethiopia, Guinea, Mauritius and Niger). Although not many African countries have ratified these conventions, many of them have national legislation on maternity protection in line with international labour standards. Figure 2.1 shows that almost half of the countries adopted at least 14 weeks of maternity leave (48.1 per cent), while one-third establishes from 12 to 13 weeks of leave.⁴

As mentioned above, Ghana has so far only ratified Convention No. 103, which specifies that maternity leave shall have a minimum duration of 12 weeks (see Appendix I for an overview of Statutory Maternity Protection Provisions in Ghana in comparison with relevant ILO conventions and recommendations). However, while providing a maternity leave duration in line

⁴ It is important to note that access to maternity leave is crucially dependent on who pays for related cash benefits (e.g. employer funded, social insurance schemes, tax-funded cash transfer schemes). For an international overview see Addati et al. (2014).

Figure 2.2: Source of funding of maternity leave cash benefits, 2016

Source: ILO Conditions of Work and Equality Department.

with this Convention, the country does not currently comply with its funding requirements, where it is stated that the entitled cash and medical benefits for maternity leave “shall be provided either by means of compulsory social insurance or by means of public funds” and that “in no case shall the employer be individually liable for the cost of such benefits due to women employed by him”. In Ghana, nonetheless, the employer is still held responsible for providing cash benefits to mothers on leave, which dramatically reduces its effective implementation. This is also in contrast with the regional pattern of providing maternity leave benefits funded by social insurance, or a combination of social insurance and employer liability (mixed systems), where almost two-thirds (63.4 per cent) of countries provide social insurance schemes, especially in West and Southern Africa (Figure 2.2).

Another main aspect of maternity protection is related to social protection policies which serve as an important tool in reducing poverty and inequality in a sustainable manner. They are designed to help preventing individuals and families from entering poverty or provide a route out of it and aim to improve access to health care and education. Only in recent years, attention has been given to the need to develop a more comprehensive social protection system that would also reach the most vulnerable in the population and thereby help to facilitate poverty reduction and human development. In this context, in 2012, the International Labour Conference (ILC) adopted the Social Protection Floors Recommendation (SPF), 2012 (No. 202), providing its now 187 ILO member states with guidance in implementing their social protection floors (SPF) and developing comprehensive social security systems. As laid down in the Recommendation, nationally-defined SPFs should guarantee effective access to essential health care and basic income security that allows life in dignity, throughout the life cycle (ILO, 2012). These guarantees should include:

- Access to essential health care, including maternity care;
- Basic income security for children, providing access to nutrition, education, care and any other necessary goods and services;
- Basic income security for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability;
- Basic income security for older persons.

The social protection floor concept is firmly anchored in the National Social Protection Policy of Ghana (NSPP, 2015), launched in June 2016, which “seeks to cater for the entire life-cycle, fill social protection gaps and strategically balance social assistance, social security and productive inclusion” (*ibid*: 2). Moreover, the report identifies three main categories of groups at risk of vulnerability: the chronically poor (such as rural unemployed and subsistence smallholders), economically at risk (e.g. food crop farmers and workers in the informal economy) and socially vulnerable (including victims of domestic violence and female-headed households), which enhances the necessity of addressing policies to these groups.

Recognizing the importance of social protection for inclusive and sustainable development and the challenge of reaching the large majority of workers in the informal economy, the Government of Ghana introduced several new schemes and programmes designed specifically to include the poor and vulnerable. These initiatives include the National Health Insurance Scheme that exempts vulnerable groups (including pregnant women) from paying contributions (2004); Ghana School Feeding (2005), the Labour Intensive Public Works Programme (2012), of which about half of the beneficiary workers are women; and the Livelihood Empowerment Against Poverty (LEAP) cash transfer programme (2008), which targets women in particular. Women currently constitute slightly more than half of beneficiaries (139,366 out of 246,115) (ILO, 2015: 26).

Lastly, since Ghanaian economic structure is characterized by a strong informal economy, the ILO Transition from the informal to the formal economy Recommendation, 2015 (No. 204), also provides guidance for the extension of maternity protection for workers in the informal economy, since these workers are insufficiently or not covered by formal arrangements or social security benefits. According to the GSS Integrated Business Establishment Survey (GSS, 2015: 14-15), only 9.5 per cent of businesses in Ghana are formal, which means that the large majority (90.5 per cent) of establishments are informal. Moreover, most of the informal businesses are in the industry (91.6 per cent) and services (90.4 per cent) sectors, with the agricultural sector being the one with relatively less informality (75.1 per cent).

2.1.2 Maternity leave and medical benefits

According to national legislation (Labour Act 2003, Act 651), the duration of maternity leave in Ghana is currently 12 weeks⁵ and there is no requirement for previous length of service, as in some other countries (Addati et al., 2014). Albeit in accordance to ILO Convention No.

⁵ According to Recommendation No. 95 [Article 1 (1)] the maternity leave provided should be extended to a total period of 14 weeks where necessary to the health of the woman and wherever practicable.

103 of 1952, the most recent Convention No. 183 and Recommendation No. 191 of 2000 extended this period in order to improve women and children's health conditions and income security. Convention No. 183 indicates that a "woman [...] shall be entitled to a period of maternity leave of not less than 14 weeks" including a "period of six weeks' compulsory leave after childbirth". R191 goes beyond this and suggests that members should "endeavour to extend the period of maternity leave [...] to at least 18 weeks".

With respect to cash benefits and funding, new mothers are entitled to maternity leave cash benefits at 100 per cent of previous earnings, which are expected to be paid fully by the employer (Addati et al., 2014). Employers continue to directly and fully fund maternity cash benefits although ILO Convention No. 103, ratified by Ghana, stipulates that employers shall in no case be individually liable for the costs of maternity leave [Article 4 (8)]. Relying on full or partial employer liability is problematic in countries where legislation is not enforced and where there is no effective monitoring on employers complying with their duties, even for workers in the formal economy. In addition, Convention No. 183 explicitly discourages reliance on employer liability as it may entail disincentives for employers to recruit, retain and promote women workers (ILO, 2016). Therefore, the ILO Committee of Experts on the Application of Conventions and Recommendations prompted the Government of Ghana to "ensure that cash maternity benefits are provided by means of *compulsory social insurance* or out of *public funds* and not paid by the employers in the public and private sectors" (ILO, 2014: 531) as a way of allowing more women to benefit from maternity protection. This is extremely important since the Ghanaian maternity leave provision covers only a small percentage of women. Addati et al. (2014: 144) estimate that just around 10 to 32 per cent of employed women receive cash benefits around childbirth in Ghana.

Moreover, Hampel-Milagrosa (2011) argues that women face a "motherhood penalty", which prevents them from finding work in the formal economy. In the informal economy, however, lack of social protection results in many women being forced to reduce maternity leave to 'a few days off'. Therefore, new policies should also focus on extending maternity protection to workers in the informal economy, as advised in ILO Recommendation No. 204 on the transition from the informal to the formal economy.

One way of improving women's situation would be to set up a social security system moving away from employer liability. According to Article 4 of ILO Convention No. 103, women workers shall also be entitled to medical benefits, including prenatal, childbirth and postnatal care as well as hospitalization where necessary. As in the case of maternity leave benefits, employers shall not be individually liable for the costs of medical benefits. In addition, where women do not qualify for such benefits, they shall be entitled to adequate benefits out of social assistance funds. This has been successfully addressed by the Ghanaian National Health Insurance Scheme (NHIS), in which pregnant women are exempted from fees and receive free ante-natal, delivery and neo-natal healthcare service. However, this initiative is still not able to cover the majority of women, as we will analyse further in this section under social protection policies in Ghana.

2.1.3 *Employment protection and non-discrimination*

The Ghanaian Labour Law, 2003 (Act 651) protects employment during maternity, prohibiting dismissal during maternity leave on the grounds of maternity [Article 57 (8)]. In addition, a worker's employment is terminated unfairly if the only reason for the termination is due to

the pregnancy of the worker [Article 63 (2e)]. However, in order to conform to Convention No. 103,⁶ the Government would have to expand this provision by not allowing notice of dismissal to be made on *any* ground during the protected period. In any case, particularly pregnant women in the informal economy often hide their pregnancy from their employers as long as possible, fearing that they may lose their job (Osei-Boateng, 2011). This is due to on-going cases of unfair dismissal, pregnancy related discrimination in the formal economy⁷ and lack of provisions that protect women's rights to return to the same or an equivalent position after return from maternity leave, as set out in Convention No. 183 [Article 8 (2)].

There are also currently no provisions addressing discrimination against pregnant women *seeking* employment (as set out in Convention No. 183). In addition, there continue to be examples of poor practice in both the formal (public and private) and informal economy where female workers are expected to sign written agreements that they will not become pregnant within a certain number of years of employment (as confirmed through key informants in this study). Similar evidence is presented in a study about maternity protection in Cape Coast (Box 2.1).

In this respect, ratification of Convention No. 183 would be a step further for Ghana and could support the adoption of new measures that would ensure the non-discrimination employment policies related to maternity, including protection of employment during pregnancy and a period following her return to work [Article 8 (1)],⁸ as well as with respect to accessing employment [Article 9 (1-2)].⁹

Box 2.1: A Case study of maternity protection practices in informal economy in Cape Coast, Ghana

Kumi-Kyereme and Boachie-Mensah's (2012) study on Human Resource Practices in the informal economy in Cape Coast, Ghana, focused on women workers in the following areas of activity: Gari Processors, Palm Kernel Oil Processors, Food Vendors, Dressmakers, Fish Processing. Apprentice Dressmakers were the group facing the poorest conditions, as pregnancies were forbidden for them. They were dismissed immediately if their pregnancy was discovered by their employers. Such conditions are of strong concern as forbidding pregnancies can lead to abortions which constitute a considerable health risk and frequent cause of maternal death. Although pregnancies were not prohibited among the Food Vendors group, they were not welcome as they were regarded as interfering with their work. The other groups of employees were allowed to get pregnant, but were mostly only given a few weeks' unpaid leave after birth. Within the fish processing group, some women returned to work two weeks after delivery as they needed the income to provide for themselves and their family. These women were able to bring their new-born babies to work with them. The most generous leave allowance was provided for women working in the Palm Kernel Oil Processors group. Although the largest group amongst them (8/20) also only took 2 weeks' leave (supposedly mainly for financial reasons), almost one third of them (7/20) took four months' leave and more.

⁶ Art. 6 of Convention No. 103 states that "while a woman is absent from work on maternity leave [...], it shall not be lawful for her employer to give her notice of dismissal during such absence, or to give her notice of dismissal at such a time that the notice would expire during such absence".

⁷ See e.g. <http://www.myjoyonline.com/news/2013/october-3rd/female-teachers-in-ashanti-region-lose-jobs-for-being-pregnant.php> [Accessed November 2016].

⁸ The length of this period would be prescribed by national laws or regulations.

⁹ Required measures include a prohibition from requiring a test for pregnancy or a certificate of such a test when a woman is applying for employment.

Furthermore, ratification of the Workers with Family Responsibilities Convention, 1981 (No. 156), would allow a transition towards creating effective equality of opportunity and treatment for men and women workers:

[...] each Member shall make it an aim of national policy to enable persons with family responsibilities who are engaged or wish to engage in employment to exercise their rights to do so without being subject to discrimination and, to the extent possible, without conflict between their employment and family responsibilities [Article 3 (1)].

2.1.4 Health protection in the workplace

Current Labour Law, 2003 (Act 651) follows some of the recommendations established in the ILO Maternity Protection Convention No. 103's corresponding Recommendation No. 95 of 1952. For instance, provisions stipulate that, unless with her consent, an employer shall not assign or employ a pregnant woman to do any night work¹⁰ or overtime until the child is eight months old [Article 55 (1)]. Furthermore, provisions in the Ghanaian legislation go even beyond Recommendation No. 95 by stating that an employer shall not assign a pregnant woman worker to a post outside her place of residence after the completion of the fourth month of pregnancy, if the assignment, in the opinion of a medical practitioner or midwife, is detrimental to her health [Article 56 (1)].

Related to other safety measures, there is a general obligation for employers to ensure that every worker employed by them works under satisfactory, safe and healthy conditions [Article 118 (1)]. There are, however, no requirements to undertake workplace risk assessments to identify work prejudicial to the health of the woman or that of her child, as well as the development of protective measures related to maternity [Article 5].¹¹ This gap in provisions can have severe consequences for maternal and child health in the short and long-run.

Health protection at the workplace is for the first time addressed under Convention No. 183 [Article 3] that affirms that members should "adopt appropriate measures to ensure that pregnant or breastfeeding women are not obliged to perform work which has been determined by the competent authority to be prejudicial to the health of the mother or the child, or where an assessment has established a significant risk to the mother's health or that of her child". Moreover, Convention No. 183's corresponding Recommendation No. 191 lists the following activities as situations in which protective measures should be taken:

- arduous work involving the manual lifting, carrying, pushing or pulling of loads;
- work involving exposure to biological, chemical or physical agents which represent a reproductive health hazard;

¹⁰ Night work refers to work between the hours of 10pm and 7am.

¹¹ Article 5 (2) sets out that work prejudicial to her health or that of her child should be prohibited during pregnancy and up to at least three months and longer if the woman is nursing her child, including in particular (a) any hard labour involving (i) heavy weight-lifting, pulling or pushing; or (ii) undue and unaccustomed physical strain, including prolonged standing; (b) work requiring special equilibrium; and (c) work with vibrating machines. Women involved in such work should be entitled to a transfer to another kind of work not harmful to her health or that of her child.

- work requiring special equilibrium;
- work involving physical strain due to prolonged periods of sitting or standing, to extreme temperatures, or to vibration [Paragraph 6(3)].

Hence, Recommendation No. 191 also suggests that measures should be taken to provide an alternative to such work in the form of:

- elimination of risk;
- an adaptation of pregnant and nursing women's work conditions;
- a transfer to another post, without loss of pay, when such adaptation is not feasible; or paid leave, when such transfer is not feasible [Paragraph 6(2)].

2.1.5 Breastfeeding support at work

The ILO Maternity Protection Convention No. 103 states that women shall be entitled to interrupt their work to breastfeed their child [Article 5] and that breastfeeding breaks shall be remunerated as normal working time [Article 5 (2)].¹² Ghana followed the African trend¹³ to introduce paid breastfeeding breaks by implementing this entitlement in its Labour Act, 2003 (Act 651), entitling women to one paid break per day for a maximum of 12 months [Article 57 (6-7)]. There are currently no provisions requiring employers to provide breastfeeding facilities at the workplace as encouraged in Recommendation No. 95 [Article 3 (2)].

Health protection and breastfeeding

The positive health effects of breastfeeding for both infant (Duijts et al., 2010; Horta et al., 2007; Horta and Victora, 2013; Léon-Cava et al., 2002; Paul, 2004) and mother (Ip et al., 2007; Labbok, 2001; Léon-Cava et al., 2002; Paul, 2004) – and hence potential benefits of breastfeeding support at work – have been well documented.¹⁴ Exclusive breastfeeding can substantially reduce early childhood mortality, particularly in developing country settings with high rates of miscarriages as well as maternal and infant mortality (Arifeen et al., 2001; Aidam et al., 2005a, b; Cattaneo and Quintero-Romero, 2006; Doherty et al., 2012; Horta and Victora, 2013; Labbok, 2006; Mihrshahi et al., 2007).

Due to lack of workplace support to enable exclusive breastfeeding, mothers often have to resort to alternative feeding methods. Infant formula is not easily accessible in all areas of the country, is expensive and has to be prepared under clean sanitary conditions – which is not always the case (Lakati et al., 2002b; Léon-Cava et al., 2002; Otoo et al., 2009; Paul, 2004). As a result, teas, porridges and other semi-solid foods are often introduced too early

¹² Corresponding Recommendation No. 95 [Paragraph 3 (1) adds that nursing breaks should be extended to a total period of at least one-and-a-half hours during the working day wherever practicable.

¹³ Whereas in 1994 only 37 per cent of African countries offered paid nursing breaks, this number had increased to 76 per cent by 2013 (Addati et al., 2014: 104).

¹⁴ The benefits of breastfeeding for mothers include a reduced risk of breast and ovarian cancer. For breastfed babies benefits include short-term effects such as a stronger immune system and lower risk of infection. For instance, they are less likely to suffer from diarrhoea, respiratory and middle-ear infections than formula-fed babies (Horta and Victora, 2013; Paul, 2004). Infants who are exclusively breastfed for the first six months are 14 times more likely to survive than infants who are not breastfed at all (United Nations, 2013b).

in life with detrimental health outcomes for the child (Aidam et al, 2005; Arifeen et al., 2001; Labbok, 2006).¹⁵

According to Jones et al. (2003), 13 per cent of cause-specific under-5 deaths in developing countries could be prevented through availability of breastfeeding interventions to 90 per cent of the target population (exclusive breastfeeding for six months).¹⁶ There is therefore a need to ensure that women are advised appropriately in ante- and postnatal counselling. Research has shown the efficiency of this type of support in Ghana and also demonstrates the cost-effectiveness of breastfeeding advice/counselling in comparison with other forms of intervention (Adam et al., 2005). This intervention resulted in almost doubling exclusive breastfeeding rates. Their study therefore suggests the Ghanaian Government should invest in adequate training for breastfeeding counsellors.

However, given that employment provides one of the key barriers to exclusive breastfeeding for six months, it also highlights the need to extend breastfeeding support to the workplace in order for such interventions to be more effective. It does not take much for small employers to create the minimum enabling conditions to help continue breastfeeding. Examples include the re-arrangement of working time (Lakati et al., 2002a, b), as well as the provision of private facilities or areas/spaces and adequate hygienic conditions which allow safe breastfeeding and breast milk expression and storage (ILO, 2012c; Paul, 2004; WHO, 2000). In addition, there is a need to educate both employers and all employees about the need to accept and assist breastfeeding mothers in order to create a supportive organizational environment (Chow et al., 2011; Ismail et al, 2012; Mensah 2011a, b).

Firm-level benefits of breastfeeding

Although research on the business case for supporting breastfeeding is scant, there is some evidence of potential firm-level benefits to employers. Business lactation programmes (which involve offering employees private space and facilities to breastfeed or express milk) have been identified as low-cost investments with positive spin-offs, including reduced maternal absenteeism, improved retention and recruitment of women workers, and increased employee morale (Cohen et al, 1995; Galtry, 2003; Martin, 2007; Mensah 2011a, b; Ortiz et al, 2004; Paul, 2004).

Two closely related Ghanaian studies by Mensah¹⁷ (2011a, b) investigated the impact of support for breastfeeding mothers on their level of satisfaction and commitment to their jobs. In Ghana at least 50% of women return to work by the time their children are three months old and stress associated with returning to work in combination with lack of support (both at work and at home) can lead to reductions in breast milk supply (see also Otoo et al., 2009).

¹⁵ Early childhood mortality is often due to malnutrition and inadequate complementary foods and this impact is increased in unhygienic settings (Labbok, 2006; Paul, 2004).

¹⁶ The causes included diarrhoea, pneumonia and neonatal sepsis. The study took into account that women living with HIV can transmit the virus to the child through breastfeeding. Otherwise breastfeeding would have been estimated to prevent 15 per cent of infant deaths.

¹⁷ The study draws on 260 questionnaires, completed by breastfeeding mothers (aged 24-41) working full-time (including five different types of organisations – hospitals, schools, banks, NGOs and government ministries – which were selected as they were among the few organisations in Ghana which employ a high percentage of women). No reference is made to the size (number of employees) of the organisations included in the study.

In turn, further stress is transferred to the job and ability to focus on work-related tasks is reduced, as illustrated by one of Mensah's cases:

“Because I am always on my feet working, I don't get enough breast milk for my baby which could be due to work related stress. Today, I was only able to express 2oz for my son which I know will not be enough for him till I get home. [...] I am here working but to be frank with you I cannot concentrate well at all. I think about my son too much and I make a lot of mistakes” (Mensah 2011b: 94).

Nevertheless, in Ghana (as in other countries), the benefits that employers gain from supporting breastfeeding employees remain underexplored and there is strong evidence for the persisting barriers that impede the continuation of (particularly exclusive) breastfeeding upon return to paid employment (Otoo et al., 2009). In their study of perceived incentives and barriers to exclusive breastfeeding among Ghanaian women in the Eastern Region of Ghana, Otoo et al. (2009) found that working mothers did not have enough time to breastfeed their infants exclusively either because of the short maternity leave or the inability to find a convenient feeding location. This is also reflected in high breastfeeding initiation rates but decline over time depending on timing of return to work. Therefore, alternatives to allow mothers to exclusively breastfeed their children up to the age of six months is extremely important for health reasons and firm productivity, and it should thus be taken into account by firms and the Government.

2.1.6 Childcare provisions in the workplace

Ghana's Labour Law currently does not include statutory provisions for employers to offer childcare facilities. Whereas in the informal economy, women often bring their babies to work with them, in formal employment it is more difficult to combine work and childcare (Clark, 1994; Kyereme and Boachie-Mensah, 2012; Quisumbing et al., 2007). Since having the infant nearby also helps to facilitate exclusive breastfeeding for mothers, ILO Maternity Protection Recommendation No. 95, [Article 3 (2)] suggests complementing the provision of breastfeeding facilities with day-care solutions, at least partly financed by the community or compulsory social insurance schemes. However, as the burden of the entire costs for day nurseries falls mostly on the employer, an unintended consequence is that employers may decide not to hire women of childbearing age (ILO, 2014).

Consequently, rather than making the provision of childcare facilities compulsory for employers, there is a need to recognise that childcare support can take many different forms. There are also some solutions which are of low cost to the employer and therefore particularly suited for smaller employers. These include the provision of opportunities to bring children to work in an emergency (Becker et al., 2008). Literature on childcare provisions at work in Ghana is extremely scant. Hein and Cassirer (2010) provide examples from Denmark and Singapore of firms that had converted office space into a family room where older children could do their homework before or after school or do other activities. A hotel complex (*Complexo Palhota*) in Mozambique allocated one hotel room as a breastfeeding room to its largely female workforce. The room is equipped with clean water and a refrigerator. In addition, in order to reduce absenteeism and improve productivity, the hotel allows employees to bring their babies to work if there is no alternative available (ILO, 2012b). With respect to more formal provisions, cooperation between different small employers in the same geographic location is a practical solution, particularly if the number of staff with young children is

very small (Hein and Cassirer, 2010; Oganowski and Ostendorf-Servissoglou, 2011). Such collaborations or inter-enterprise crèches tend to be very flexible, permitting employers to contribute depending on their financial situation or level of demand. Although shift work and atypical hours can provide a barrier to such partnerships, they may become possible again, and even be particularly suitable, in settings where such working time patterns are a common feature across a number of firms (e.g. in the same industry).

In addition, opportunities for fathers' involvement in childcare are essential for gender equality. The need for increased paternal involvement in parenting is driven not only by high rates of maternal employment, but also by changing patterns of kin support. The level of childcare support available from extended family networks varies, influenced by cultural, ethnic and socio-economic factors but, due to social and economic changes, it is generally much less available today than it was a few decades ago (Mahon, 201; Mensah, 2011b; Miller-Cribbs and Farber, 2008). There is therefore a need for employers to also support fathers with family responsibilities.

2.2 Other social protection policies in Ghana

2.2.1 *Social protection system including the nationally-defined social protection floor*

The Ghanaian Labour Law, 2003 (Act 51) requires employers to provide some statutory benefits to employees, including paid sick leave, paid maternity leave, severance pay and paid annual leave. In addition, all workers in the formal economy should contribute to and be registered with the pension scheme and health insurance, administered by the Social Security National Insurance Trust (SSNIT) and the National Health Insurance Fund (NHIF). The public pension scheme provides benefits in case of old age, invalidity or death to workers in the formal economy and dependents/survivors. Nonetheless, as already discussed with respect to maternity leave, most paid employees in Ghana do not have access to these benefits as evasion is a concern, and in any case, these regulations are not enforced in the informal economy (Osei-Boateng and Ampratwum, 2011).

The need for gender-sensitive social protection programmes

It is generally recognized that the exposure to life cycle risks and the occurrence of poverty and ways in which it is experienced is differentiated by gender and that women are more likely to be affected by social exclusion (Antonopoulos, 2013; Holmes and Jones, 2013; Jones et al., 2009; Kabeer et al., 2013; Tessier et al., 2013). In addition, women's gendered employment patterns¹⁸ and their greater representation in the informal economy result in lower rates of social security coverage of women (in terms of the number of women covered, the level of benefits and contingencies covered) (Tessier et al., 2013). It has therefore been recognized that broader and more comprehensive social protection programmes also require a gender-sensitive approach to their design, implementation and evaluation. Furthermore, given the potential of

¹⁸ As Tessier et al. (2013: 3) summarise, women are over-represented in low productivity, low paid, temporary or part-time and poorly protected jobs (World Bank, 2011; ILO, 2013). Particularly in developing countries, formal employment is frequently found in sectors where men are overrepresented (such as manufacturing or financial services) and sectors where women are over or equally represented (such as personal services, retail and hospitality) are frequently characterised by precarious forms of employment.

such policies to act as a transformative tool for the most vulnerable and marginalized groups in the population, they can promote greater gender equality and female empowerment (*ibid*).

ILO (2015: 154) has estimated that even a modest cash transfer benefit for households with pregnant women and children under five would have a significant impact in achieving direct reduction in the extreme poverty rate by 2.2 percentage points, as well as promote maternal and child health. Annually, the necessary government budget would be 0.59 per cent of government revenue (excluding grants) using 2014 data, and would reach only 0.42 per cent of the budget (corresponding to 0.12 per cent of GDP) by 2018.

In its draft national social protection strategy, Ghana adopted UNICEF's definition of social protection, which includes the achievement of gender equality in its core objectives (GNSPS 2012, p. 4). However, much more could be done in Ghana to make social protection programmes gender-sensitive at each step in the implementation cycle, starting from targeting and registration processes that are easily accessible for women to ensuring benefit design that meets their needs. For example, the LEAP programme could add poor pregnant women to the target population (as is currently piloted by the LEAP 1000) (see Section 2.2.2). The Labour Intensive Public Works (LIPW) programme could step up efforts to ensure the availability of childcare at the work sites, ensure that pregnant women carry out work that is appropriate for them. The LIPW programme could even provide a kind of paid maternity leave by granting women a break of 12 weeks while maintaining the payment of their wage, but leaving them on the payroll. Furthermore, the NHIS could step up efforts to enrol pregnant women and enforce the legislation that provides for pregnant women to receive the free treatment for *all* maternity-related health services. There were also discussions among national constituents of introducing a national maternity benefit programme. According to ILO calculations, to finance maternity cash benefits for poor pregnant women and mothers with children under the age of five in the order of 25 GHC per month would cost about 0.5 per cent of government expenditures or less than 0.2 per cent of GDP (ILO, 2015).

The need for increased efforts to extend social protection coverage

In Ghana, most of the existing social security provisions can be accessed by only those in formal employment (less than 10 per cent of the population), resulting in the vast majority of the poor, who tend to rely on subsistence farming and the informal economy, being unprotected (Jones et al., 2009).¹⁹ Traditional social support networks, characterised by practices of mutual help among people (mostly in the informal economy), are still deeply rooted in the country's culture (Jones et al., 2009; Kumado and Gockel, 2003; Osei-Boateng, 2011; Osei-Boaeng and Ampratwum, 2011). Such organised groups tend to request monthly dues and provide basic benefits in time of illness, the birth of a baby or bereavement (Clark, 1994). Nevertheless, these social networks have been deteriorating with increasing modernization (Jones et al., 2009; Osei-Boateng, 2011). Urbanization processes and economic constraints have influenced the nature of kinship ties and people's ability to provide for family members. Increasingly, members of the family are too poor themselves to provide support and long-standing traditional saving systems are often targets of theft and misuse (Osei-Boateng, 2011). Consequently, the need for a broader and more comprehensive social protection provision is more pressing than ever.

¹⁹ While some of the existing schemes provide for voluntary coverage for those in the informal economy, take-up is still very limited.

In response to these challenges, in the past few years, Ghana's poverty reduction strategies have been focusing on vulnerability reduction (Jones et al., 2009). In 2007, a National Social Protection Strategy (NSPS) was completed and it was later revised in 2012. More recently, a new National Social Protection Policy (NSPP) was adopted at the end of 2015 with the aim of facilitating "harmonization, coordination, improved targeting and relevant capacity building at all levels" (NSPP, 2015: viii). Relatedly, a number of social protection programmes have been launched in recent years. Two of these, the National Health Insurance Scheme (NHIS) and the Livelihood Empowerment Against Poverty (LEAP) initiatives, are particularly relevant to the provision of maternity protection measures and will therefore be discussed in more detail in the following sub-section.

2.2.2 Recent reforms of social protection programmes in Ghana

In line with ILO Social Protection Floors Recommendation, 2012 (No. 202), Ghana has demonstrated progress with respect to basic social security guarantees. Recommendation No. 202 sets out that governments should "ensure at a minimum that, over the life cycle, all in need have access to essential health care and to basic income security which together secure effective access to goods and services defined as necessary at the national level". Below, we discuss two important national initiatives that have taken place in Ghana regarding universal health access and basic income for vulnerable residents.

The National Health Insurance Scheme (NHIS)

The National Health insurance Scheme (NHIS) was established under the National Health Insurance Act (NHIA) of 2003 to replace the previous "cash-and-carry" system which involved significant out of pocket payments. The NHIS (including all district schemes) has a single benefit package that is set by Legislative Instrument No. 1809 and is described by the NHIA as covering 95 per cent of the disease conditions that affect Ghanaians. Benefits include outpatient and inpatient services – such as diagnostic testing, specialist care, most forms of surgery, hospital accommodation, and maternity care services, including complicated deliveries, emergency care, and drugs on the NHIA Medicines List. However, *de facto* limitations in this comprehensive package arise from the limited availability of certain services and pharmaceuticals, particularly in rural areas (ILO, 2015), and barriers to access for informal economy workers (Alfers, 2013).

Maternal health is covered as one component of the National Health Insurance Scheme (NHIS) which was launched in 2004 under the NHIA.²⁰ A reform approved under the Act 852 in 2012, aimed to "remove administrative bottlenecks, introduce transparency, reduce opportunities for corruption and gaming of the system, and make for more effective governance of the schemes".²¹ The objective of the NHIS is to "ensure equity in health care coverage, access by the poor to healthcare services and protection of the poor and vulnerable against financial risk" (National Health Insurance Act 852, 2012: 7).

The scheme is funded by four main sources: 1) a 2.5 per cent of each person's 18.5 per cent contribution paid by workers and employers in the formal economy to SSNIT; 2) the

²⁰ There are 5 benefit packages of the NHIS: 1. out-patient services; in-patient services; 3. oral health; 4. maternity care; 5. emergencies. Maternity care comprises of: antenatal care; deliveries (normal and assisted); caesarean session; post-natal care. Obstetric and gynaecological emergencies are also included under the "emergency package".

²¹ Available at: <http://www.nhis.gov.gh/nhia.aspx> [Accessed July 2017].

National Health Insurance Levy (NHIL), which is charged at a rate of 2.5 per cent on specific goods and services, namely on alcohol, cigarettes and luxury goods; 3) individual contributions by members; and 4) miscellaneous other funds from returns on investment, Parliament or donors [Article 41]. The NHIL is by far the largest source of financing and, in 2009, accounted for about 61 per cent of the NHIS's total income. At the same time, premiums paid by members account for less than 5 per cent of total inflows to the NHIS (Kusi et al. 2015: 3). Moreover, in 2009, formal economy contributions made up 15.6 per cent and the informal economy only 3.8 per cent (ILO, 2015: 38), which means that formal workers end up paying a larger share of contributions, although they represent only 10 per cent of members. In 2013, Social Security National Insurance Trust (SSNIT) contributors constituted 3.6 per cent of active members, while informal workers (including the self-employed) represented 33.6 per cent (NHIA, 2013: 16).

Despite being one of the few countries in the Sub-Saharan region that has a national health insurance scheme with a strong legislative basis providing for universal health coverage, the scheme still presents a range of flaws. For instance, only 39 per cent of Ghanaians are covered under the NHIS (NDPC, 2015: 150) and, according to ILO (2015: 69), an even smaller percentage among lower income quintiles share of the population. The majority of members are those exempt from fees, which will be discussed further in this sub-section. In Table 2.1, we are able to see the share of population that was enrolled in the NHIS in 2013 by region. As we notice, enrolment is quite well balanced geographically. Nonetheless, in Brong Ahafo, Upper East and Upper West regions, there are relatively more people enrolled in the NHIS as share of total population in these respective areas. Brong Ahafo also has a large enrolment as a percentage of the total Ghanaian population, especially taking into account that the region's population represents less than 10 per cent of the country's population.

Membership for workers is mandatory and employers must ensure that each employee is registered under the NHIS. If not, employers are subject to a fine of up to 200 penalty units for each employee [Article 27 (13)]. Under the National Health Insurance Act of 2012, "employer means a person who employs a worker under a contract of employment", the latter being defined as "an agreement between an employer and a worker whether express or implied and if express whether oral or in writing" [Article 27(15)]. The Act thus also includes informal workers, but enforcement remains an important issue.

Contributions from workers in the formal economy are part of their social security contributions to SSNIT. However, registration is not automatic and they need to pay registration fees to receive their NHIS cards (ILO, 2015: 71; Kusi et al., 2015: 3). Those not registered with SSNIT pay a flat-rate annual premium, thus allowing informal workers to be covered by the health insurance scheme as well (Kusi et al. 2015). Table 2.2 introduces the share of informal workers that were part of the NHIS in 2014. Although the national average is below one-third of total members, some regions, such as Greater Accra and Western, are slightly above the national average of 30.7 per cent. Contribution levels are determined by the National Health Insurance Authority (NHIA). In 2012, the range of contributions was set between GH¢ 7.20 (US\$3.78) and GH¢ 48 (US\$25.19), and the average premium per month was reported as GH¢ 8.5 (US\$4.46) for Ghana as a whole (Kusi et al., 2015: 3; Saleh, 2013) and GH¢ 21 (US\$11.02) for the Greater Accra Metropolitan Area (Blanchet et al, 2012).²²

²² Exchange rates are measured by values of December 31st 2012.

Table 2.1: Population and NHIS enrolment distribution, by region, 2013

Region	Population distribution* (% of total population)	Health insurance coverage (% of total enrolment)	Enrolment (% of total population)
Ashanti	5,123,308 (19.39%)	1,715,388 (16.91%)	6.49%
Brong Ahafo	2,476,765 (9.37%)	1,353,840 (13.34%)	5.12%
Central	2,359,817 (8.93%)	866,936 (8.55%)	3.28%
Eastern	2,822,047 (10.68%)	1,110,121 (10.94%)	4.20%
Greater Accra	4,297,721 (16.26%)	1,280,257 (12.62%)	4.84%
Northern	2,657,329 (10.06%)	880,517 (8.68%)	3.33%
Upper East	1,121,620 (4.24%)	643,278 (6.34%)	2.43%
Upper West	752,477 (2.85%)	422,417 (4.16%)	1.60%
Volta	2,270,208 (8.59%)	910,569 (8.98%)	3.45%
Western	2,546,468 (9.64%)	961,873 (9.48%)	3.64%
National	26,427,760 (100%)	10,145,196 (100%)	38.39%

Source: NHIA (2013: 15).

Note 1: *Population distribution was based on the 2013 projected population.

Note 2: Calculation by the authors.

Table 2.2: Distribution of NHIS membership, by region, 2014

Region	Informal workers (% of total members)	Exempt members (% of total members)	Total members	Total population	% of total population
Ashanti	567,390 (32.7%)	1,169,039 (67.3%)	1,736,429	5,252,099	33%
Brong Ahafo	409,360 (25.8%)	1,179,710 (74.2%)	1,589,070	2,539,027	63%
Central	196,919 (29.1%)	479,625 (70.9%)	676,544	2,419,138	28%
Eastern	354,725 (34.7%)	666,801 (65.3%)	1,021,526	2,892,989	35%
Greater Accra	411,556 (35.6%)	744,130 (64.4%)	1,155,686	4,405,760	26%
Northern	264,746 (22.8%)	897,532 (77.2%)	1,162,278	2,724,130	43%
Upper East	182,025 (28.3%)	460,213 (71.7%)	642,238	1,149,816	56%
Upper West	130,151 (29.9%)	305,273 (70.1%)	435,424	771,393	56%
Volta	336,454 (32.2%)	709,441 (67.8%)	1,045,895	2,327,278	45%
Western	381,815 (35.3%)	698,523 (64.7%)	1,080,338	2,610,481	41%
National	3,235,141 (30.7%)	7,310,287 (69.3%)	10,545,428	27,092,111	39%

Source: NDPC (2015: 150).

Note: Calculation by the authors.

While districts schemes are encouraged to charge contributions according to income, most have adopted a flat rate.

Another important feature of the NHIS is that it actively targets the most vulnerable by exempting children under 18 years-old, pregnant women, older persons above 70 years, people with mental disorder and indigents from paying any contribution (National Health Insurance Act, 2012 [Article 29]). However, apart from pregnant women and indigents, exempt members are still required to pay an annual registration fee in the value of GH¢ 4 (US\$0.99) (Kusi et al., 2015). In 2014, exempted members represented 69 per cent of all active members, which exceeded the target for the year of 63 per cent (NDPC, 2015: 150).

In 2013, women were a large part of members, reaching 58 per cent (NHIA, 2013: 15). Of these enrolled women, 81 per cent gave birth in hospitals, compared with 57 per cent of non-members. They were also more likely to access antenatal care (94 per cent compared to 76 per cent) and experienced half the number of infant deaths compared with their uninsured counterparts (Mensah et al., 2010 in Holmes and Jones, 2013: 249). Although these outcomes suggest that the scheme is working towards its aim of reaching out to the vulnerable segments of the population and of focusing on reproductive health, more efforts are needed to increase coverage among the poor: it is estimated that 65 per cent of the top quintile are registered with the NHIS, compared to less than a third of the bottom quintile (ILO, 2015: 71). Another study by Kusi et al. (2015: 6) shows that, under those who are insured, 13.5 per cent belong to the poorest quintile of the sample, while the top quintile represents 28.5 per cent of the insured population, more than twice as much as the poorest share. This could be explained by the fact that NHIS agents receive a share of the fee paid by SSNIT contributors, while there is no remuneration for the new exempt registrations. Therefore, there would be a lack of incentive for NHIS agents to actively register the poorest income quintile in Ghana (ILO, 2015: 71). Other evidence suggests that low registration of the poorer share of population arises from the relatively high fees of registration and premium for those not benefiting from an exemption. Although the NHIS aims to facilitate access to healthcare through low premiums and exemptions, lack of finance remains the most cited barrier to registering for the scheme for 90 per cent of non-members (Holmes and Jones, 2013; Mensah et al., 2010; Walsh and Jones, 2009). This barrier is also affected by uncertainty about which services are covered for free (Singh et al. 2015). A more recent study shows that the reasons for the lack of registration varies among income groups. Of the 64 per cent uninsured Ghanaians that claimed that premium or registration fees were too expensive, 31.2 per cent belong to the poorest quintile. Meanwhile, 22.6 per cent of households answered that their 'family members don't fall sick, so there is no need for being insured', and 14 per cent stated other reasons for not registering, such as the perceived poor quality of care, registration difficulties, lack of trust in NHIS officials and inadequate benefit package and lack of understanding of who and what services were covered for free (Kusi et al., 2015: 7).

Further issues were identified regarding the posture of hospitals towards NHIS members. For instance, there were cases in which hospitals refused people treatment because patients were NHIS card holders (Alfers, 2013). The evidence suggests that some health providers prefer patients who can pay on the spot (as under the previous cash-and-carry system) rather than having to deal with NHIS members whose cases involve time-consuming paperwork to

submit the related claims and delays in getting reimbursed by the NHIS.²³ Such findings are particularly interesting given that one of the stated aims of the NHIS is to eliminate ‘out-of-pocket payment being required at the point of service use’ (Ghana Ministry of Health, 2004; Mensah et al., 2009).

Since 2013, the Ghanaian Government has been trying to increase coverage among the poorest and reach the most vulnerable population by automatically registering with NHIS all households that benefit from the Livelihood Empowerment Against Poverty (LEAP), a cash-transfer initiative (see following section). In that way, recipients of LEAP benefits would be automatically recognized as indigents and benefit from the exemption of fees and premiums, and be provided their health insurance card, thus contributing to the increasing enrolment of the bottom quintiles of income distribution in Ghana (ILO, 2015).

Livelihood Empowerment Against Poverty (LEAP)

Another important element of the social protection system is the Livelihood Empowerment Against Poverty (LEAP) initiative, a ‘quasi conditional’²⁴ cash transfer programme which was launched in 2008. LEAP is a social assistance programme targeted at the extreme poor²⁵ and it is funded from general revenues of the Government of Ghana (50 per cent), donations from the Department of International Development (United Kingdom) and a loan from the World Bank (Yeboah et al. 2016). Extreme poor individuals are those whose per adult equivalent consumption of the household falls below the national lower poverty line, which was GH¢ 792 (US\$ 198)²⁶ a year (GH¢ 66 or US\$ 16.5 monthly) in 2013 (MofGCSP, 2016: 31; Cooke et al., 2016: 5). LEAP’s coverage has increased from 1,654 households in 21 districts in 2008 to 213,048 households in 2016, covering all 216 districts of Ghana.²⁷

Although LEAP targets the extreme poor, not all of them are eligible to the program. To be a recipient of LEAP, Ghanaian households must include at least one family member from one of the following specific social categories:

- aged sixty five years (65) and above without any form of support;
- severely disabled without productive capacity;
- orphaned and vulnerable children (OVC);
- pregnant women and mothers with infants (up to 15 months-old).²⁸

²³ Similar problems were reported in our interviews with women workers and key informants (delays in the NHIS paying the health care provider led to a preference of cash payments over membership cards).

²⁴ ‘Quasi-conditional’ refers to the fact that families are only made aware of the conditions of the scheme, but not penalized for non-adherence (Holmes and Jones, 2013).

²⁵ The scheme uses complex targeting methods, including the selection of deprived districts as well as a combination of community-based selection and proxy means testing (Holmes and Jones, 2013).

²⁶ Exchange rate of 16th November 2016, where GH¢ 1 was equal to US\$ 0.25. This rate shall be used in all conversion ahead.

²⁷ Available at: <http://leap.gov.gh> [accessed in July 2017].

²⁸ This category was added in 2015 under the LEAP 1000 initiative.

Payments are made on irregular cycles, usually every two months,²⁹ and depend on the numbers of eligible members in the household:³⁰

- one eligible member: GH¢ 64 (US\$ 15.85);
- two eligible members: GH¢ 76 (US\$ 18.82);
- three eligible members: GH¢ 88 (US\$ 21.80);
- four or more eligible members: GH¢ 106 (US\$ 26.25).

Amounts are transferred by a third party, currently the Ghana Interbank Payment and Settlement System (a subsidiary of the Bank of Ghana) to pay beneficiaries electronically. The provider uses licensed financial institutions located within a radius of 5 kilometres of the respective community and the beneficiary identification is through biometric fingerprint.³¹

LEAP cash transfers are made to the main caregiver, who in most circumstances is a woman, on cases of cash transfers related to children, older persons and persons with severe disabilities. As regards the pregnant women and children under 15 months-old category, LEAP 1000 has included an additional 6,423 households since 2015, however, this number represents only 2 per cent of total beneficiaries.³² Overall, women represent 56 per cent of the programme's beneficiaries.³³

Women under the LEAP 1000 initiative are among the population at highest risks of vulnerability in Ghana, as shown by the Baseline Evaluation Report (MofGCSP, 2016). Comparing the LEAP 1000 households to the rural households in the Northern and Upper East Regions from the Ghana Living Standards Survey (GLSS 6 of 2014), LEAP 1000 households' consumption is much lower. GLSS households spent on average about GH¢ 189 (US\$ 47.25) per adult per month, while the treatment group of LEAP 1000 spent only GH¢ 89.66 (US\$ 22.41). Moreover, the latter spent more than three quarters (77.8 per cent) of their budget on food, followed by housing items (5.3 per cent), such as candles, health supplies (4.4 per cent), clothes (2.7 per cent) and education (3.3 per cent) (*ibid*: 27-30).

Another issue is with respect to child labour. From 2012 onwards, the LEAP excluded the "abstention from child labour" from the original co-responsibilities, which is a lost opportunity for the country to eliminate the worst forms of child labour and improve the well-being of vulnerable children (ILO, 2015: 27). According to the ILO Convention on the minimum age for admission to employment, 1973 (No. 138), which is in force in Ghana since 2011, members should effectively abolish child labour for children under 15 years.³⁴ Child labour

²⁹ In 2016, payments were made in end January, end March, end May, early August and mid-October. Available at: <http://www.ghana.gov.gh/> [accessed in November 2016].

³⁰ Available at: <http://leap.gov.gh> [Accessed in July 2017].

³¹ *Ibid*.

³² *Ibid*.

³³ *Ibid*.

³⁴ Children under 13 to 15 years-old can perform light work according to national laws if those are not harmful for their health and development and don't prejudice their school attendance [Article 7].

Table 2.3: Children of age 7-14 taking part in selected activities, 2015 (in percentage)

Variable	Male	Female	Total
Collecting water	17.1	55.7	35.7
Collecting firewood	9.4	21.5	15.2
Taking care of children, cooking or cleaning	21.1	60.2	39.9
Land preparation or planting	43.3	32.0	37.9
Weeding, fertilizing or other non-harvest	43.5	31.7	37.9
Run or help in non-agricultural business	1.2	2.5	1.8
Livestock-related activities	21.5	7.2	14.6
Collecting nuts, fruits, honey, other food	3.4	7.0	5.1
Casual labour	6.5	6.3	6.4
Wage, salary, payment in kind labour	3.4	2.8	3.1

Source: MofGCSP (2016: 36-42).

Note: Selected data refers to LEAP eligible households.

in Ghana is also very gender-related, as showed in Table 2.3, and girls end up performing much more labour than boys in general. Although boys have a higher participation rate on half of the activities, the gender disparity between those activities is smaller than on activities dominated by girls. For instance, taking care of children, cooking or cleaning is done by 60.2 per cent of girls between 7 and 14, while only 21.1 per cent of boys perform this task, which indicates a 39.1 percentage-point difference between the two. Likewise, collecting water is performed by 21.5 per cent of girls and 9.4 per cent of boys, representing a difference of 12.1 percentage points. On the other hand, the activity that boys are mostly engaged in, i.e. weeding, fertilizing or other non-harvest task, is done by 43.5 per cent of boys and 32 per cent of girls, which in the end represents a disparity of only 11.5 per cent – a much lower rate than the care work of girls, for instance.

In this way, although the LEAP programme does have a gender perspective by including pregnant women and directing payments to the main caregivers, there are still a lot of improvements to be made, especially corresponding to coverage of the extreme poor that do not follow under the above categories, a more regular payment of the transfer, and perhaps re-including the conditionality on absence of child labour, which would improve girls' lives as well. However, institutional and organisational constraints are holding back the expansion of the programme and weak inter-agency coordination is making it difficult to ensure the effective implementation and complementarity of the programme (Holmes and Jones, 2013; Jones et al., 2009; ILO, 2015).

Lastly, the Government should keep in mind ways of funding future transfers, since donor support is scheduled to end by 2017, which will require the Government to fully fund the

LEAP (ILO, 2015: 28). ILO (2015) has, however, estimated that an expansion of the LEAP programme to full national coverage could achieve direct reduction of extreme poverty rates by 2.2 percentage points. Required funding for this initiative would be in the value of 0.25 per cent of total government revenue (excluding grants) for the year of 2016 (*ibid*: 154). Therefore, it does not seem that continuance of the programme without foreign grants will be a major risk for the Ghanaian Government's budget in the near future.

2.3 Maternity protection and access to health care services in rural areas

Maternity protection practices and challenges are also shaped by the geographic location of the workplace. This becomes particularly evident in the case of workers in remote rural areas for whom their workplace is often their community/village or even their home. In Ghana, 70 per cent of residents live more than 8 km from the nearest health care provider (NDPC, 2015: 149). Figures also show that only 35.5 per cent of all rural births were attended by skilled health personal (data from 2003 and 2008), confirming poor access to healthcare in rural communities (Johnson et al, 2015: 8). Many of these women also cannot afford any time off work before their baby is born. In Ghana, as in many countries with high maternal mortality, long distances, geographical barriers, lack of transport and associated high costs, poor infrastructure, communication facilities, as well as lack of community effort to organise transport lead to often life-threatening delays in reaching health care facilities (Holmes and Kennedy, 2010; Masters et al., 2013; Munjanja, 2007). Evidence indicates that, if there is an accessibility time of 30 minutes to services, which is crucial for women's health and survival, maternal mortality is reduced drastically (Grieco and Turner, 2005). There is therefore a need to improve accessibility to emergency obstetric care since emergencies provide a major risk for maternal mortality (Babinard and Roberts, 2006; Holmes and Kennedy, 2010).

In this context, the 'three delays' model, developed by Thaddeus and Maine (1994), identifies the following delays as key barriers to improving maternal health outcomes: 1) in recognising the need for care; 2) in reaching care; and 3) in receiving adequate treatment at the facility. According to Holmes and Kennedy (2010), overcoming the 'second delay' is of greatest significance in poor remote populations that tend to have poor health status and access to health care, and therefore makes a disproportionate contribution to inequitable maternal health outcomes. Nevertheless, the 'second delay' – transport to care – is often overlooked (Holmes and Kennedy, 2010; Orcutt, 2013; Transaid, 2014).

There is a considerable literature which looks at ways to overcome transport barriers which are suited to particular local context in different African countries (Green et al., 2013 – Nigeria; Grieco and Turner, 2005 – Ghana; Heyen-Perschon, 2005 – Ghana; Orcutt, 2013 – Zambia; Tanzarn, 2013 – Uganda; Transaid, 2014 – Ghana). Improvements of transport management practices can be achieved without having to incur any significant costs; much can be done by simply making better use of the resources already at hand. For instance, at the community level, there is a need to maximise the use of locally available means, such as intermediate non-motorised transport, private, or commercial vehicles. In addition, the increasing availability and relative affordability of mobile phones can play an important role in tackling communication barriers as one contributing factor to delays in reaching care. According to Holmes and Kennedy (2010), experience has shown that, when awareness is

raised, communities are often willing to pool resources, time and transport to support families in overcoming the 'second delay'.

Another key factor in relation to the 'three delays', which can be expected to be more difficult to overcome, is related to deeply embedded gender inequality and social exclusion (Tazarn, 2013; Transaid, 2014). Women may not be able to afford money for health care and transport, or they may lack their husbands' permission to seek care. As Grieco and Turner (2005) point out, "decisions about when and where to seek care are usually made by an uncle (or occasionally by the husband); without their input, a woman would be unlikely to seek care on her own". In addition, in some communities orthodox medicine is still rejected and traditional birth attendants (TBAs) and traditional healers are preferred (see e.g. Hillet al 2014; Moyer et al., 2013; Tabi et al 2006). Furthermore, in his study of factors determining the propensity to seek maternal-child health services in rural Ghana, Addai (2000) found education and religion to be the main predictors. Cultural barriers of this nature therefore also influence the first delay (Munjanja, 2007). There is thus a need to raise awareness among rural communities, including expectant fathers and other men about the risks associated with delays in seeking care. However, such schemes require strong leadership and management skills and are difficult to scale-up (Holmes and Kennedy, 2010).

Regarding awareness, one way that the Government of Ghana has tackled this issue is through the implementation of the Community-based Health Planning Service (CHPS) zones.³⁵ Experiments have shown that "engaging a resident nurse in a community and involving traditional leaders and community members in the provision and management of healthcare substantially reduces childhood mortality, builds male participation in family planning and improves health system accountability" (Johnson et al., 2015: 2). However, the current CHPS initiative is structured as such that it does not promote skilled birth care in rural areas, but merely refer pregnant women to health centres. At the same time, CHPS has done a good job in encouraging people into accessing high quality professional care for antenatal, delivery and post-natal treatments, but more positive results would emerge if this initiative could be backed-up by an extension of existing coverage of nearby health centres (*ibid*).

2.4 Summary and discussion

The above analysis of the existing policy, legal and regulatory framework and current practices in relation to maternity protection at work demonstrates that a distinction has to be made between larger employers, smaller employers (who may also be relying on informal contracts) and the self-employed. Maternity protection practices are also shaped by the location of the workplace and the extreme poverty experienced by many workers and self-employed, particularly in rural areas.

In Ghana, women are entitled to 12 weeks of paid maternity leave. However, as most women work in the informal economy, the majority of women workers currently does not benefit from such provisions. The main issue is that maternity cash benefits have to be fully paid by employers, resulting in a detrimental disadvantage for women when job-seeking. This stands

³⁵ See <http://www.ghanahealthservice.org/chps/> [Accessed July 2017].

against the solidarity principle of social (and maternity) protection arrangements, which tries to spread risks and related cost if a contingency occurs across society. At the moment, there is no statutory paternity or parental leave. The law also entitles new mothers to paid breastfeeding breaks, but unless women have their babies nearby, they are finding it difficult to combine work with exclusive breastfeeding. There is therefore an urgent need to raise awareness among employers of the important business and social outcomes of breastfeeding support at work and of maternity protection more generally. Adequate maternity protection addresses several of the SDGs and can particularly contribute to the improvement of maternal and child health.

Closely related to breastfeeding support is the need to provide childcare opportunities at the workplace or nearby. Although employers often assume that childcare support is very costly, there are examples of solutions which are of low cost. Particularly in the informal economy, childcare is often provided informally and women can bring their children to work with them. Consequently, although smallness and informality can present barriers to providing maternity protection measures (particularly with respect to paid maternity leave), there also is evidence that small firms can facilitate the provision of low cost measures such as breastfeeding and some childcare support.

The majority of women workers in Ghana are working in the informal economy and are often self-employed. They therefore benefit less from social protection, as related measures are mostly linked to formal employment. In order to empower women in this context, there is a need for social protection policies and programmes which are gender-sensitive, inclusive and specifically targeted at women. However, in order for such supports to be effective, it is crucial to understand the pattern of gender relations for the design of effective gender-sensitive interventions.

Great efforts have been made to extend social protection coverage to the poorest Ghanaians and to develop measures to accelerate progress towards the target of SDGs 3 on healthy lives and 5 on gender equality. In this context, the examples of NHIS and LEAP were discussed and related challenges identified. Key steps include the launch of free enrolment of LEAP beneficiaries in the NHIS and free NHIS registration for pregnant women and mothers with infants. However, despite remarkable achievements in improving access to health care, the NHIS currently only reaches 39 per cent of the population in Ghana.

In addition to budgetary and administrative challenges, in rural areas, the so-called ‘three delays’ were discussed as another key barrier affecting workers’ access to and take-up of NHIS membership and antenatal visits, skilled attendants at birth, as well as timely access to quality emergency obstetric care. Another recurring theme in the literature is the important role of culture and wider societal attitudes with respect to women’s role as mothers and workers, including local differences, in influencing maternal health outcomes in Ghana.

3. Methodology

3.1 Scope of study and theoretical approaches

In this section we consider theoretical explanations of why employers might implement maternity protection and support employees with family responsibilities, theorising benefits and sources of limitations to such supports. We adopt a context and gender-sensitive approach to the study of maternity protection measures in Ghanaian workplaces, which takes into consideration motivations and experiences of employers as well as workers and other stakeholders. Although including firms of all sizes, the research focuses particularly on SMEs and the informal economy, to reflect the business landscape in Ghana. However, it is recognised that ‘informality’ takes different forms and is difficult to define.¹ For the ILO Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), the term “informal economy” “(a) refers to all economic activities by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements; and (b) does not cover illicit activities [...] [Paragraph 2].²

Lewis et al. (2014) identified a number of theories useful for the study of maternity protection in small firms. In this study we have adapted their framework, taking into account the varied Ghanaian context. We recognise that there is considerable heterogeneity between different types of employers and employees, depending on location, size of firm, sector, level of formality, skill level and other variables. In addition, conditions are very different in the case of self-employed women. Our aim is therefore to capture all of these different interests, needs and concerns.

Small employers in both the formal and informal economy often perceive the provision of maternity protection measures as burdensome. According to Lewis et al. (2014),³ the lower levels of voluntary implementation of maternity protection measures such as maternity leave in SMEs compared with larger firms can largely be explained by the key characteristics of small firms which can be summarised as follows, even if there are fine nuances between and amongst firms of different sizes with regard to the strength in which they figure:

- resource constraints;
- high failure/turnover rates lead to a focus on short-term planning and immediate business outcomes;

¹ See Appendix II on characteristics of the informal economy.

² For the purposes of Recommendation No. 204, “economic units” in the informal economy include: (a) units that employ hired labour; (b) units that are owned by individuals working on their own account, either alone or with the help of contributing family workers; and (c) cooperatives and social and solidarity economy units [Paragraph 3].

³ See also Fashoyin (2006) on employment relations and human resource management in small firms from an African perspective.

- organizational and work cultures are strongly related to the attitudes of owners;
- due to the pressures they face, often antipathetic to government intervention/regulation and prefer more informal approaches to labour management;
- shaped by their context (e.g. societal/local norms, values and culture).

However, the literature mainly focuses on the constraints of small firms in providing adequate working conditions in the formal economy where flexibility and lack of formality are mostly presented as negative features (Lewis et al., 2014). However, this focus on formal arrangements may mask good and mutually beneficial (as well as bad) maternity related practices in smaller firms (Dex and Scheibl, 2001; Stumbitz et al., 2017). As a result, informal practices, such as flexible maternity leave, breastfeeding or childcare support in SMEs will tend to be less visible to outsiders and therefore less likely to contribute to wider pressures to formalise support.

In the informal and low wage context of this study, a social exchange theoretical perspective (Blau, 1964; Emerson, 1976) is likely to be more significant in understanding the provision of effective and accessible maternity protection measures. Social exchange theorists argue that employers and employees acknowledge the importance of reciprocity or 'give and take' (Barratt and Mayson, 2008; Chow et al., 2011; Dex and Scheibl, 2001, 2002; Mensah, 2011a, b). For instance, although formal support practices are generally less common in SMEs than in larger organizations, there is evidence that in cases where employees receive informal support and perceive a family-friendly organizational culture overall, this results in increased staff motivation, improved satisfaction and retention (Cegarra-Leiva et al., 2012; Gerlach et al., 2013). Establishing a family-supportive image also improved the quality of job applicants and therefore reduced recruitment costs in these studies. Consequently, it is suggested that such forms of reciprocity can lead to positive outcomes for both employers and employees.

Reciprocity, however, is also influenced by employee and employer expectations, which in turn are influenced by perceptions of what is fair and equitable. Drawing on social justice perspectives, it is argued that workers tend to compare their employment conditions with those of colleagues and employees working for comparable firms. Such social comparisons influence their sense of entitlement to supports such as maternity protection (Lewis and Smithson, 2001; Herman and Lewis, 2012; Lewis et al., 2012; Stumbitz et al., 2017). Subjective sense of entitlement is related to - but not necessarily the same - as objective entitlements. It is not only influenced by national maternity support policies but also adapted to the perceived economic reality. As Lewis et al. (2012) argue, if workers perceive the feasibility of additional support to be lower in small firms, they tend to be satisfied with less rather than comparing their entitlements with those in larger organizations. Low expectations can therefore limit what support is asked for and taken up. Social comparisons are not gender neutral; women workers across firms of all sizes tend to have a lower sense of entitlement with respect to, for example, fair pay or other employee benefits (Herman and Lewis, 2012).

Social justice perspectives thus highlight the importance of the issue of power and agency (or lack thereof) and the need to explore gendered social relations in our framework. Although a gender lens is important, most (Western) gender models stem from developed countries

and cannot be applied to Africa unproblematically. A model is needed which is sensitive to the Ghanaian context and also to local variations within the country. In order to understand deeply contextualised gendered accounts, it will be necessary to explore local kinship structures, state policies, as well as political and socio-economic processes (Clark, 1994).

We therefore draw on the Social Relations Approach⁴ (Kabeer, 1994) which informs our analysis of maternity protection at work in developing country contexts. This approach is particularly appropriate for our study, as it focuses on the most vulnerable women workers, primarily those who are positioned in sections of the informal economy that are hardest to reach by maternity protection policies and regulations (Kabeer et al., 2013). Whereas ‘social relations’ refer to those relationship processes which lead to various groups of people being differently positioned in society, ‘gender’ adds an additional dimension to social relations which is concerned with the position of men and women in these social processes. Aiming to address the subordination, discrimination and inequality faced by women, the approach calls for a redistribution of power which goes beyond economic development by also attending to human well-being (survival, security and autonomy) more generally (Kabeer, 1994; March et al., 1999; Miles, 2014; Razavi and Miller, 1995). This wider conceptualisation of empowerment is of key importance for interpreting the findings of this study as the power relations of our participants can be expected to vary widely, particularly between wage and salaried women workers in the formal economy and self-employed workers in the informal economy. Furthermore, this approach emphasizes the need to explore the role of collective action in achieving greater maternity protection, for example through civil society organizations, women’s groups and associations of different kinds.

Finally, the theory of ‘embeddedness’ (Granovetter, 1985) serves as a useful lens through which to research maternity protection in Ghana. Granovetter (1985) questions the notion that individuals make decisions independently and outside their social context. With respect to this study, this approach takes account of the different ways in which maternity protection is shaped by cultural, social and structural influences, as well as, for instance, differences between and within regions and types of work.

3.2 Method

The fieldwork was conducted in 2014. Our approach involved a detailed review of relevant literature and existing data and practices, as well as the policy, legal and regulatory framework in place. This was complemented by qualitative interviews with 25 stakeholders,⁵ 29 employers, 34 employees and 37 self-employed (own-account) workers. These were spread across three contrasting regions: the Upper East, which is currently experiencing the highest rate of maternal mortality in Ghana in combination with high levels of rural poverty; the Eastern Region, which is characterised by lower levels of poverty but still high levels of maternal mortality; and Accra which currently has the country’s lowest maternal mortality rate (see also Table 3.1).

⁴ See also <http://www.ilo.org/public/english/region/asro/mdtmanila/training/unit1/plngaps1.htm>.

⁵ Government ministries, social security institutions, LEAP, NHIS, GYEEDA, labour inspectorate, workers’ and employers’ organizations, civil society and research institutions, and other associations or community groupings.

The semi-structured interviews were conducted face-to-face where feasible and by telephone in only a few cases. Most interviews were undertaken in the workplace (e.g. businesses, markets, rural communities) to gain a deep understanding of the work environment of participants.⁶ Interviews were conducted in the language that interviewees felt most comfortable speaking. We were supported by a team of local research assistants who were acting as interpreters, enabling us to minimise communication barriers, and also helped us to establish trust and gain access to communities in a number of occasions. Employers were recruited with experience in employing pregnant women and workers with family responsibilities. The criterion for recruiting workers and self-employed women was that they had at least one child aged 10 years or younger and that they were self-employed or in paid employment at the time prior to new motherhood. We also interviewed six wage and salaried workers and self-employed fathers across the three regions. The sample included firms of different sizes, with a focus on small firms and those operating in the informal economy, to reflect the business landscape in Ghana. Whereas our overall strategy ensured that more typical cases were covered, we also applied an element of purposeful sampling to ensure that some examples of good practice were included. After a total of 100 interviews with workers and employers, and 25 with stakeholders, no new thematic categories emerged and, thus, saturation had been achieved (Robson, 2002). Focus group were conducted with two small rural groups in the Upper East (FG-UE1; FG-UE2) and one in the Eastern Region (FG-ER1),⁷ as well as one group discussion in Accra with key stakeholders at the national level (FG-AC1).⁸

The interviews covered the key components of the policy, legal and regulatory framework for maternity protection in the Ghanaian context, including (1) maternity leave and medical benefits, (2) employment protection and (3) non-discrimination, (4) health protection, as well as (5) breastfeeding and childcare support.

Our analytical framework consisted of two main phases. The first, mostly deductive, phase focused on analysing the qualitative data in relation to the above mentioned key components of maternity protection in the different types and forms of workplaces (size of firm; in/formal; urban/rural). During this phase, further patterns emerged on the issues and concerns raised by participants (identified through key words, which were combined in clusters) which suggested a more thorough exploration of these in a second analytical phase (Guest et al. 2012). These subsequently emerging themes turned out to be of considerable importance in shaping availability and take up of maternity supports across the range of different types of workplaces studied and were related to the importance of gendered cultural norms, traditions and expectations; workplace culture and reciprocity; livelihoods and self-employment; and access to health services for rural workers.

⁶ Although conducting interviews in the natural setting of the worker provides an in-depth insight into the working conditions of interviewees, it can lead to the participant being distracted by other workers or customers during the interview. Given the population under investigation, it was also not possible or regarded as appropriate to record the interviews in most cases (Summer and Tribe, 2008). However, extensive notes were taken and reviewed shortly after each interview.

⁷ Participants of these groups included men and women from the community, community leaders, traditional birth attendants and community health volunteers.

⁸ This group was attended by delegates from relevant government ministries and the International Labour Organization, as well as a public health consultant.

Table 3.1: Overview of interviews with employers, employees and self-employed workers

Region	Formal/Informal Economy	Employers		Employees		Self-Employed (own-account)	Total
		SME	Large	SME	Large		
Greater Accra	Formal	4	3	4	6		17
	Informal	4		1		12	17
		11		11		12	34
Eastern Region	Formal	5		4	1		10
	Informal	2		4		12	18
		7		9		12	28
Upper East	Formal	6	1	10	2		19
	Informal	4		2		13	19
		11		14		13	38
Total		29		34		37	100

Limitations of the study relate to the limited validity and generalizability of the findings. However, given the exploratory nature of the study, the main aim of the project was to gain an understanding of the complexity and multi-faceted reality and experience of maternity protection at work in Ghana.

4. Findings – Current maternity protection practices, challenges and unmet needs

Policy, legal and regulatory framework coverage, gaps and challenges with respect to maternity protection were shaped by the type of work as well as the work environment. In this study, three main categories of work could be identified which were affected by the current policy, legal and regulatory framework to varying extents.

- The first category refers to formal economy businesses in the public and private sector, as well as larger NGOs and donor organisations. It mainly includes large employers (100+ staff) that are likely to have a Human Resources function. In this category, the current statutory maternity provisions as set out in the Labour Law, 2003 (Act 651) and in line with ILO Convention No. 103 were most commonly implemented. See Appendix I for an overview of existing legal entitlements related to maternity protection as well as gaps in provision.
- The second category refers to SME employers and employees, including micro and small businesses (in both the formal and informal economy) with 1 to 29 members of staff, as well as medium sized organizations with up to 99 employees. Whereas medium sized firms are more likely to provide maternity supports in line with statutory requirements, statutory maternity provisions are less common in small and, particularly, micro businesses. In small firms, the employment relationship was found to be characterised by blurred boundaries between more and less formal work arrangements and highly influenced by the closeness of relationships between employers and employees. For those in this category who work in the informal economy, work arrangements mostly rely solely on verbal agreements.
- The third category includes the self-employed, ranging from those with a decent livelihood to the poorest self-employed. This category operates outside the reach of Ghana's Labour Law and access to social protection measures is often limited, particularly in remote rural areas. In the absence of employer and state provisions, the family and local community often becomes the main source of maternity support.

As discussed earlier, workplaces can take very different forms, including office settings, market places, as well as farms and communities/villages for many rural/farm and domestic workers. Embedded in these different types of workplace, work and employment, five key themes were identified which shaped women's experiences of work during pregnancy and early motherhood: 1. Awareness of maternity protection: the policy, legal and regulatory framework and beyond; 2. Gendered cultural norms, traditions and expectations; 3. Workplace culture and reciprocity; 4. Livelihoods and self-employment; and 5. Access to health services for rural workers. These themes are discussed in more depth below, and illustrated through views of employers, workers and stakeholders.

4.1 Awareness of maternity protection – the policy, legal and regulatory framework and beyond

A dominant overall theme throughout the employer and employee data was the limited awareness of workers' rights and employers' duties with respect to workplace supports for pregnant women and new mothers. However, these awareness gaps and related implications differed between workplace contexts and employee groups. Below we discuss awareness among employers and employees and the somewhat paradoxical impacts of lack of awareness on employees' perception of support in different contexts.

4.1.1 Employers' awareness of workers' rights and employers' duties

Among employers, two main groups could be identified: 1) those who were either ignorant of the law altogether or had limited detailed knowledge of entitlements; and 2) employers with a detailed understanding of the law but who mostly did not proactively inform staff of their entitlements. The first group mostly comprised smaller employers, but also included a few managers in large firms who did not have a *detailed* understanding of the law. This included, for example, not being sure about exact entitlements regarding an element of maternity protection. For instance, a senior manager in a large health care organization thought it was a legal requirement to provide 2 hours of daily breastfeeding breaks instead of 1 hour (ER-AC12). In a few cases, small employers who did not know the laws on maternity thought they were doing their employees a favour or rewarding good work (see Section 4.3) by e.g. providing some payment for maternity leave and (un)paid time off for antenatal visits or breastfeeding (e.g. ER-AC10; ER-ER1; ER-UE7). The second group mainly included large employers. Across the data set, we found only 3 cases (ER-AC2; EE-AC7; EE-AC1), all large formal employers in Accra, who proactively informed staff of their entitlements, for example, by holding annual staff days to remind employees of maternity and other entitlements (EE-AC2).

4.1.2 Employees' awareness of workers' rights and employers' duties

Among employees, we could also identify two key groups: 1) employees (of mostly large firms) who were aware of the law more generally, but often unsure about exact entitlements; and 2) employees in smaller workplaces with a very limited understanding of their entitlements, as well as those who were entirely unaware of maternity protection law. The following excerpts provide examples of partial knowledge of entitlements by employees in medium and large organizations (Group 1):

"Apart from maternity leave, we don't know of any other company policy targeted at pregnant and breastfeeding mothers. Although there is a women's [interest group] in our company, they hardly look at issues concerning maternity protection. Also, there is always nothing on maternity protection at our management and general meetings as the discussions are mostly centered on company growth" (employee of a medium-sized company in the urban Upper East, EE-UE10).

"The [employer] allows extra breaks for breastfeeding women, but this is not a written policy. There is no specified time given to you to go and breastfeed – it is more like a favour" (hospital worker in the urban Upper East, EE-UE8).

In one case, an NGO worker in the Upper East (formal, 50 staff, EE-UE7) felt that her employer had abused her lack of knowledge about her right for additional leave in the case of pregnancy related illness:

“When I realised I was pregnant at 2 weeks, I had some problem and had to take 2 weeks total bed rest – I just had to do it. What made it more challenging was that the organisation felt it was too much time off and should be taken off my annual leave. I was not in good health and then received a letter saying it would come out of my 21 days annual leave... but I had to look after the baby. I had to ask for leave from the Tamale office, the area manager here could not approve leave. Even if the Tamale manager had been here, he would not have considered me. It was an issue of ignorance. I was not sure of labour laws and maybe he did not know or was playing on my ignorance”.

Most of the women in smaller workplaces in our sample had limited or no sense of entitlement to maternity protection. Complete lack of awareness with respect to maternity support measures was particularly widespread amongst workers in the informal economy and in remote rural areas where ignorance is an important barrier to improving maternal health outcomes (see Sections 2.3 and 4.5).

4.1.3 Consequences of lack of detailed knowledge of entitlements in different workplace contexts

A complex picture emerged of the ways in which this widespread lack of knowledge of entitlements affects women's perceptions of maternity supports available among different employee groups. On the one hand, we identified examples in our data (in the formal economy) where employees did not fully appreciate additional maternity supports because they did not realise that their employers provided supports beyond statutory requirements (see also Section 5.2.2). It emerged that 7 (out of 9) large firm employees had received some form of support beyond the requirements of the law, such as, for example, 2 hours daily for breastfeeding instead of 1 hour, or the ability to work half days at full pay for a certain period after the return to work. However, they took these provisions for granted due to lack of knowledge of the limits of their legal entitlements. For instance, this employee in a large organization in Accra (EE-AC7) stated that she had received 4 months of paid maternity leave (instead of three as stipulated by the law), but was not aware that this provision was exceeding legal requirements:

“They look at the Ghanaian labour laws and extract what suits them and include it in our contract. [...] The support is limited to the barest minimum allowed in our labour laws and there is no flexibility”.

On the other hand, we identified some examples of employees in small firms who had received supports falling short of legal entitlements and did not challenge this inadequate provision, as well as of workers in the informal economy who were mostly grateful for any employer supports they received. The following examples illustrate this:

“I was off for 3 months after the baby was born. I was only paid half of my salary during this time and found it very difficult to get by. But I realise that, compared to other women I know, I am relatively well off by getting 3 months paid leave and appreciate it” (teacher at private school in urban Upper East, EE-UE2 – entitled to 4 months leave).

“Our employer does not pay us leave but we can bring babies to work and breastfeed. [...] No, there are no supports from employers for leave. What I would wish the Government to do for pregnant women and mothers with small babies is to implement a law that would help us get financial support a few months before and after delivery” (bread maker in the urban Eastern Region, EE-ER6).

Cases like these suggest a generally lower sense of entitlement to support among workers in smaller workplaces, and particularly among those in the informal economy, as they tended to be out of reach of statutory maternity provisions. In our data these women tended to regard any support they received as favour, while employees in larger firms had higher expectations of support and also sometimes perceived extra supports beyond statutory provisions as part of their entitlements. It is notable that the large firm employees included in our study were in skilled jobs and that large firm employees in low paid jobs may have a much lower sense of entitlement to support.

However, we also found examples across workplace contexts of women who feared to ask employers for specific supports as a consequence of lack of (detailed) knowledge of entitlements. For instance, this employee of a large international organisation (EE-AC7) in Accra stated that she preferred to make arrangements for antenatal checks outside working hours, rather than asking for support. Fearing negative reactions from managers and colleagues, she, like other interviewees did this to avoid being perceived as a burden at work:

“I used to get to the clinic at 6am and would be done by 7.30am and from there come straight to work so my work time was not affected and I did not need to ask for permission to attend ANC. What I noticed was that if you go often, your supervisor may not say no but eventually you will start getting looks from your colleagues and your supervisor may also show displeasure”.

Lack of awareness of maternity protection rights and duties was thus found to affect both employers and employees in negative ways. From the perspective of employers, not proactively informing staff of their rights in detail can result in employees not appreciating – sometimes costly – supports beyond legal entitlements. From the perspective of employees, not knowing their rights can lead to exploitation and discrimination of pregnant workers and those with family responsibilities (see also Section 4.3). There is therefore a need for initiatives that raise awareness of employees’ rights and employers’ duties with respect to workplace maternity and paternity supports.

4.2 Gendered cultural norms, traditions and expectations

Lack of knowledge or understanding of legal entitlement provides a context where cultural norms, traditions and expectations with respect to gender roles can go largely unchallenged. The data demonstrated how views on women’s and men’s roles as workers and parents influence the nature and effectiveness of current maternity protection practices across the entire range of different workplaces. In this section we first discuss perceptions of maternity related discrimination, particularly in male dominated workplaces, and the ways in which this is manifested in larger and smaller workplaces. As assumptions about gendered parental roles

perpetuate mothers' disadvantages in the workplace, the next section examines norms, traditions and expectations of fatherhood.

4.2.1 *Experiences of maternity related discrimination and unfair treatment at work*

The subject of discrimination and unfair treatment of mothers was a recurring theme across workplace contexts. Although generally women working in formal employment had access to legal provisions with respect to maternity leave and cash benefits, a motherhood penalty in terms of career advancement or job security emerged as an important issue in male dominated workplace contexts. For example, an employee (EE-AC7), working for a large multinational company in Accra, shared experiences regarding the lack of career opportunities for women in her workplace who are, in her words, *“saddled with family”*:

“Have you seen the women who work in the [name of employer] system? Have you seen any of them rising fast on the career ladder if saddled with family? They are either unmarried or without children. In the corporate world, if a woman decides to add family and childcare to her career, she will pay a price for it”.

In our sample, there were a few specific examples of unfair treatment of mothers, but no contrary examples of positive discrimination.¹ For instance, a large firm employee (EE-AC1) in a male dominated industry stated that, in her (technical) department, women – especially mothers – were not given the same promotion and training opportunities as men. As she explained, *“I feel stuck in my technical position and would like to move to Human Resources, where more women have senior roles”*.

Moreover, we also identified two examples of employees in large organizations who reported that the maternity supports they had received were unavailable to certain staff groups, such as those still undergoing training. Cases like the following thus suggest the existence of maternity related inequality not just across, but also within workplaces:

“These services or entitlements [to maternity supports] are actually not accessible to all pregnant women. For instance, national service and orientation [staff] who get pregnant in the course of their service are asked to stay at home till they are delivered of their babies without pay or allowance. After this they are made to repeat the whole service duration of 10 months irrespective of the months they may have done prior to them being pregnant” (health worker in the urban Upper East, EE-UE6).

“When training for 6 months and then on probation for 18 months, then you are now not sacked for being pregnant anymore, but they won't pay your maternity leave. Before the [employer] would recruit very young like 18 years, but they might now appoint people at 30 and these people will have children. [...] (Do you know of other pregnant colleague's experiences?) One person got pregnant when still on probation but she got no maternity leave. So she had to resume work the next day” (police woman in the urban Upper East, EE-UE6).

¹ In this context, positive discrimination would have included the practice or policy of favouring the recruitment, treatment or career advancement opportunities of mothers (as individuals belonging to a group which often suffers discrimination).

It emerged that, across workplace contexts, fear of being labelled as ‘trouble maker’ and potential adverse consequences had a negative influence on employees’ sense of entitlement to support. As a health worker in a large organization (EE-UE11) in the Upper East argued, *“because of lack of employment you fear you may be sacked if you take legal action for other (maternity) entitlements”*. In addition we heard, second hand, of similar examples of employers ignoring the law without being challenged by employees, contributing to a wider discourse of the acceptance of maternity related discrimination and unfair treatment. Although they were not asked about this in interviews, a few formal economy workers mentioned further cases they knew of (e.g. in their families or circle of friends) where women had lost their employment in firms of different sizes due to pregnancy. According to a stakeholder from the Labour Commission (SH5), discrimination remained a persistent issue, the actual scale of which was unknown and very difficult to determine:

“People are not filing complaints on maternity issues and we have to delve deeper into the complaints to identify that they are on maternity issues. For example, a woman may face termination because she is reporting sick too often at work due to pregnancy but the reason for termination is not stated as due to pregnancy but rather as absenteeism. It is only after we delve deeper that we may find it is because the lady was sick due to pregnancy. To combat this we have found out that some organizations make women sign an agreement not to get pregnant within the first 2 years of employment. We also meet situations where some employers adopt an attitude against hiring of women due to some women taking undue advantage of their pregnancy to take too much time off, creating a disincentive against hiring of women”.

This lawyer from Accra (EE-AC8) provides a similar account, again referring to tensions between legal entitlement and employers’ reluctance to hire women employees:

“I have heard of cases of bosses sacking people and there are legal cases that get them reinstated with compensation, but this is rare. [...] But in some companies, men don’t like employing women because of this. But pregnancy is just normal. So these should be dealt with by the law. But still, if you go for an interview, you cannot say you are pregnant. [...] But companies fear such cases as there is a reputational effect, especially if the press report it”.

Similar issues were evident in smaller firms and the informal economy, where regulation is not enforced, but where employers’ main concerns were about costs. A small employer (ER-AC5) who provided good maternity support herself² gave the following account of maternity protection in SMEs, based on her conversations with other small employers:

“In Ghana, maternity is often a problem for employers, especially SMEs, because of the costs. Most SMEs are reluctant to pay women. The costs of training new staff as cover are a problem; most small employers just try to survive and if they can cut costs in any way they will – or hire men rather than women”.

² This small employer provided paid breaks for antenatal checks, paid maternity and paternity leave, flexible working arrangements upon the return to work, reallocation of tasks for pregnant and returning workers, and childcare support for children from 1.5 years.

This reflects the experiences of small employers in diverse national contexts (Lewis et al., 2014) and relates to the specific characteristics of small businesses. In our sample, a small number of small employers in the informal economy admitted they had fired women when they became pregnant, or refused to provide support during pregnancy and after the return to work. The experiences of employees are, for instance, illustrated by a farm worker in the Eastern Region (EE-ER8) who told us that she lost her job as soon as her employer found out that she was expecting a child (see Section 4.3.1 for further examples). Two years after the birth of her child, she resumed employment with the same employer, due to lack of alternative employment opportunities.

This theme demonstrates that workplace maternity discrimination remains an important issue and that regulation needs to go hand in hand with more complex and difficult culture change for maternity protection to be more effective. This will include shifting not only workplace assumptions but also family and wider societal gendered norms and values, especially concerning the role of fathers, towards a more equal distribution of family responsibilities between women and men.

4.2.2 Cultural views on the role of fathers and fatherhood practices

Across study regions and sectors, the role of the father was mostly discussed in relation to the provision of financial support only, although we also identified examples of more ‘involved fatherhood’ across regions. However, views on fatherhood varied widely within the sample, including those who did not expect fathers to become involved in childcare, others who would have liked to see them more involved, as well as those who doubted the abilities of fathers to look after their children. Particularly in rural areas, the role of fathers was mostly seen as that of material providers for the family. For instance, in a focus group in a remote rural community in the Upper East (FG-UE2) all participants agreed that there were strict rules with respect to division of labour and thus ‘tried and tested’ ways of doing things. House and care work was viewed as the responsibility of women and a man who was supporting a woman in related tasks was stigmatised as ‘pognidoo’ (womanly man). A stakeholder confirmed this:

“Fathers support to pregnant or nursing mothers in this community is virtually non-existent. This is due to the gender roles which the community holds high esteem, as such a man that is seen to be helping the wife is often teased and called a ‘pognidoo’” (community health volunteer and TBA in rural Upper East, SH25).

Another two examples of mothers accepting the limiting of the fathering role to financial support and low sense of entitlement to practical help with, or sharing of, infant care are provided by a weaver from the urban Upper East, who stated *“in all my pregnancies my husband gave me money for my antenatal checks and he bought all children’s clothes. He is very supportive, I must confess”* (SE-UE12), and a public servant from the urban Eastern Region, who argued *“my husband’s support is great in terms of finances and paying for a house help that made managing my pregnancy, childcare and work less challenging”* (EE-ER1). Both demonstrate mothers’ low expectations of any support or involvement in childcare. A range of participants, particularly stakeholders, blamed the cultural socialization of the country for the lack of support from fathers in maternity care (see Box 4.1).

Box 4.1: Examples of stakeholders' perspectives on cultural views about the role of fathers and changes that are needed

"Fathers are usually the breadwinner or contribute towards upkeep of the home in a higher proportion financially. When it comes to actual care of babies, they are quite discretionary because most men find babies too fragile and think they might use their strength to break them so they do not assist in their care. I think a system must be in place to intentionally teach fathers and future fathers and make them realize that they can do more to support their spouses in terms of direct care of children. They can take care of some domestic chores to ease the workload of their wives and partners but our culture does not encourage them to do so" (independent public health consultant, SH2).

"Fathers in Ghana need to be more supportive than our culture has made them become. They still expect their wives to serve them as they did before children came in which makes life more stressful for the women because they now have two people (father and baby) to care for instead of just the man before delivery. If for example men would help in the morning by taking care of their breakfast themselves and not still expect their wives to attend to their babies and them as well, it would be a big relief for the mothers. In the evenings they could also assist by sometimes holding the babies for their mothers to rest a while. They could also sometimes take their babies for reviews so that the mothers do not always have to ask for permission from their workplace which jeopardizes the mothers' work with some employers" (National Labour Commission, SH5).

"Most men run away from playing their role to support their spouses because they have not been taught how to do that. TUC has a Gender Desk that gives education to the men on what to do to support their spouses. At TUC we believe that we need to work along with the men to address the challenge of supporting women throughout pregnancy, delivery and afterward taking care of the growing baby and the rest of the family" (TUC, SH6).

"Which culture within Ghana encourages boys to support the care of their little siblings? Just give me one example! Why then do we complain when these boys grow into fatherhood with no clue of what men do to support their wives in childcare?" (queen mother, SH20).

However, there were some signs that things are changing, particularly in the urban areas and amongst the more educated groups, as illustrated by this quote from a small employer (ER-AC5) in Accra:

"My husband is very supportive and those of many of my friends are too. Culture is catching up! Previously childcare was the domain of women but I think it depends on factors like the education level. Many fathers now see joy in bringing their children up together with their partners".

Similarly, a large employer in Accra (ER-AC1) pointed out that *"more educated and well-travelled or exposed men are more likely to be supportive to their spouses"* and raised the need to increase awareness about the matter. Box 4.2 provides examples of involved fatherhood from mothers' perspectives. In most cases fathers are appreciated for helping rather than sharing parenting but this, nevertheless, marks a shift in normative gendered assumptions.

Thus, maternity protection is not only about women and there is an urgent need to educate the population more broadly about different ways in which fathers can better support

Box 4.2: Examples of mothers' descriptions of involved fatherhood

"My greatest support during and after pregnancy, I owe to my husband, the father of my children. He takes full responsibility for the children in all things, financially, baths them, feeds them, dresses them, takes them to school and back - in fact I owe him all the appreciation" (employee of a large formal economy organisation, EE-AC9).

"When our children were babies, my husband would let me sleep and stay up to take care of them on days I was so tired" (public servant in Accra, EE-AC7).

"My husband helps me with childcare and also with household chores. Other fathers should also help in the same way, but this is rare" (market trader in Accra, SE-AC7).

"After my son turned six month, my husband sometimes took him to work while I also went to work. This support he gave me was indeed helpful as I was now able to concentrate on my work while knowing that my son was in safe hands. He always bottle fed him and changed his diapers while keeping him at his workplace. This was essential due to my experiences with the babysitter who would sometimes leave the baby with other people while she went out to do her own things" (hospital nurse in urban Upper East, EE-UE8).

"The support I get from my partner is that he sometimes helps carry the child while I go about my household duties or even when I'm writing my lesson notes and [our daughter] is disturbing. Also when I became heavily pregnant, he was responsible for taking me to school every morning and then picking me up from school when I finished my work day. He felt riding a motor bike during that period wasn't good for my health and that of the baby" (teacher at public school in rural Upper East, EE-UE12).

pregnant women and new mothers, and also to educate employers/managers about the role workplaces can play in supporting more involved fatherhood. However, in view of the variety of current views of roles of men as fathers, including notions about womanly men, it will be important that any related initiatives adopt a culturally sensitive approach in order to ensure positive outcomes.

4.3 Workspace culture and reciprocity

Owners of small businesses and line managers/supervisors in larger businesses are all key in shaping the ways in which formal workplace policies are interpreted in practice as well as informal practices. Their positive attitudes, values, assumptions and practices relating to maternity are an important condition for effective maternity protection. While some businesses or managers appeared to be very unsupportive, negative or even hostile to maternity protection, others were found to reward loyalty of staff with better maternity protection. The latter involved processes of social exchange and reciprocity (discussed in Section 3.1) and occurred across regions and different work contexts, including small firm employees in the informal economy, as well as employees of large multinational corporations in the formal economy (albeit to a lesser extent in our sample). Specifically, a pattern emerged of the provisions of workplace maternity support embedded in workplace culture and reciprocal relationships, based on loyalty and trust.

4.3.1 Reciprocity in smaller workplaces and the informal economy

A key theme across the data was that workplace culture in smaller firms (in both formal and informal economy) was characterised by much closer relationships between employers, employees and co-workers than in large businesses, as found in other research (Lewis et al., 2014). For small firm employees (particularly in the informal economy), the level of maternity support they received at work was influenced by the quality of relationship to their employer as well as by their ability to prove themselves as assets to the company. Although informal economy workers are also in principle entitled to the same maternity protection provisions as workers in the formal economy, we could not identify a single informal economy employee in our sample, who was aware of any maternity entitlements generally available to her (see also Section 4.1). Rather, employer decisions on whether or not to provide any maternity support were made (or rationalised) on a one-to-one basis and dependent on whether the particular staff member had already proven herself as skilled, hardworking and loyal to the business.

For instance, a small interior design business owner (informal, 15 staff, ER-AC10) in Accra provided two contrasting examples of her experience with staff pregnancy, which illustrate the process of reciprocity leading to different outcomes. She described the first case as a loyal staff member whom she had employed since she started her business. When this employee was pregnant she allowed her to attend health check-ups and rescheduled her tasks (no heavy loads, no climbing, no home visits) and paid her 3 months maternity leave. She explained how for the first three months after this woman returned to work she allocated her office work and permitted her to work reduced hours so that she could breastfeed and tend to the baby. The employee could also bring the baby to work for the first 9 months until she was able to put the baby in a crèche. In the second case she discussed an employee who was already pregnant when she started to work for her but did not disclose this at the time. The employers learned about the pregnancy through another staff member and waited for the employee to tell her, but this did not happen. One day the employee started bleeding and had to go to hospital. Upon her return the employer told her that she should stay home to rest and look after herself and her baby – the pregnant woman was then made redundant. According to the employer it was not worth investing in a member of staff who had not proven her abilities, trustworthiness and loyalty.

Trust was thus highly valued and where trustful relationships had been established, particularly in the informal economy and in small firms, staff members often called their employer ‘Mama’, while employers viewed their employees as family members. This restaurant owner (informal, 15 staff, ER-ER1) in the Eastern Region provides another example of a close employment relationship in a small firm context:

“My organization is like a family business [...] and I see [my workers’] babies as mine, like a grandma. I have a worker who is a breastfeeding mother – she worked very hard during pregnancy. Three more people have been on maternity recently. I allow them to bring their babies to work. I treat them like family and I have decided to help them”.

These women who had recently been pregnant had been working for her for at least two years before they had babies and had demonstrated their reliability:

“I have every confidence in them, if I am not available they can take over, they are hardworking and reliable people. I can leave for a month if I’m on holiday as long as the resources are there. They know where to buy from or buy on credit. They know everything”.

However, the same employer also mentioned another recent case of staff pregnancy. The employee had only been working for her for two months when she found out that the woman was pregnant. According to the employer she appeared to be unreliable, as she was giving excuses that she was feeling dizzy and that she had to see the doctor, so that the employer told her not to come back. Reliability, apparently was defined in terms of not allowing any pregnancy symptoms to interfere with work, at least until a trustful relationship had been established. The employer also complained about a case in which she felt one of her staff had taken advantage of her generosity, become very unreliable (e.g. late for work) and was described as using the baby as an excuse.

This case thus provides further evidence that employer support depended on whether a trustful relationship had been established *before* becoming pregnant. However, the issue of trust is a two way process within which employers have greater power, particularly in the absence of formal protection. The examples also demonstrate that trustful relationships are vulnerable and reciprocal relationships at risk of breaking down if one of the parties feels exploited. Furthermore, they illustrate how good support practice and discrimination can go side by side in the same organization.

From the perspective of employers (independent of sector and firms size), being informed of staff pregnancy early on allows them to plan ahead and manage absence. However, in order for employers to be able to provide support early on in pregnancy, such as time off for antenatal visits and re-arrangement of tasks (see Section 5.2.1), the employee needed to trust employers and feel able to disclose their pregnancy without having to fear losing their job (see Section 4.2.1).

4.3.2 Reciprocity in large workplaces in the formal economy

In formal economy employment, the pattern around workplace culture and reciprocity took a different shape. In comparison to smaller workplaces, provision of statutory maternity protection measures (as set out in ILO Convention No. 103 and Ghanaian Labour Law, 2003, Act 651) was most likely and not dependent on loyalty and trust. However, the pattern regarding availability of supports beyond legal entitlements, in this case family-friendly practices such as flexible working arrangements and childcare support (which are not addressed in the current policy, legal and regulatory framework), strongly resembled that identified in smaller firms. Rather than having formal written policies on such provisions in place, in both the formal and informal economy, the ability to bring a child to work in emergencies or to work reduced hours after return from maternity leave was mostly dependent on, or strongly influenced by, factors such as the workplace culture and assumptions about ideal workers,³ the nature of

³ Organizational structures tend to be built around a cultural picture of the ‘ideal worker’ as someone who can work as though they have no social or caring obligations outside work. This is referred to as a male model of work as part of which work comes first and above other commitments. As a result, time to spend at work is unlimited (as reflected in the ability to be constantly visible and work long hours), and the demands of family, community and personal life are secondary (Lewis et al., 2014).

the relationship to the line manager as well as support from colleagues. Inconsistency of support was therefore a problem in this respect, which led to tensions between colleagues and managers and also affected staff motivation negatively.

For instance, two participants working for the same large employer in Accra (EE-AC1; EE-AC2) felt that the workplace culture was very individualistic and generally unsupportive of family-friendly supports beyond statutory entitlements. However, although sharing the same employer, they had different managers and their experiences with respect to their requests for maternity supports differed considerably:

“My last pregnancy was risky. I had infections and other complications and would have liked to work remotely for 2 days a week, but was not allowed although the system is in place. We have all the technical equipment to support it here, but it was still not granted in my case” (large firm employee in Accra, EE-AC1).

“I think my manager is quite understanding and I feel comfortable asking for help. As long as I get my work done, I get the support I need” (pregnant employee in large firm in Accra, EE-AC2).

These two health workers from the Upper East provide another example of maternity supports being provided on a one-to-one basis:

“I could work reduced hours for 3 months upon return from paid maternity leave, but know of colleagues who worked reduced hours until the child was one year old and of others where such arrangements had not been an option. So, not all staff are given the same opportunities. Such arrangements are different for everyone, depending on the nature of the relationship with your manager and colleagues” (hospital employee in urban Upper East, EE-UE4).

“In my organisation every nursing mother is to close an hour earlier, but this is not observed in practice. I used to close with the other workers at the usual closing time. I brought my baby to work, but had no break. My baby used to sleep on a mat by me and I did my work with the baby. [...] My schedule was so busy that I was not allowed to break as compared with those who were less busy. Others had the chance to break and go back to their quarters to breastfeed their babies. I stayed the whole day at the workplace which made the baby so tired” (health centre worker in urban Upper East, EE-UE11).

In Accra, several employers and line managers as well as stakeholders within the formal sector shared personal experiences or referred to cases that confirmed such inconsistencies in support.

4.3.3 Reciprocity among colleagues

The notion of ‘give and take’ was not only important for maternity supports between employer and employee, but also among colleagues. Social reciprocity between colleagues could be identified in both formal and informal workplaces, and played an important role in providing support, particularly with respect to childcare, mostly in workplaces where employer supports were unavailable or insufficient (see Section 5.2). For example, a health sector employee in the Upper East who brought her baby to work on a regular basis (EE-UE11) explained that the

support of colleagues was crucial for her to cope: *“When patients are around and the baby wakes up I have to let the baby cry until I have served the patients. Sometimes my colleagues will have to pick up the child to support me.”*

However, related supports were also uneven, as this example provided by an employee in a small professional services firm in Accra (EE-AC8) demonstrates:

“Colleagues do look out for you and sometimes would help with reports – you know, one good turn deserves another. [...] Actually, the men were more sympathetic, always asking if I was OK. Women see it as something everyone does... there is a saying ‘pregnancy is not a disease’ – so just get over it and be active.”

Another example for support being provided on a one-to-one basis is provided by two women shift workers (EE-AC9; EE-UE8) who pointed out that they received help from some colleagues who would look after their children during their time off, while other colleagues were very unsupportive. There could be a number of reasons for lack of support by colleagues in some contexts, including an individualistic work culture (as in case of most large firms included in this study), or experience of non- or uneven support by employer, line manager or colleagues when in the same situation.

In our sample, we found several cases in informal economy where support between colleagues was embedded in the wider organizational culture. One employer gave the example of promising support for all staff on the condition that they helped each other cover the workload through pregnancy. In this way staff learned to trust each other and were assured that colleagues would cover for them if they had to take maternity leave or other time off (see Section 5.2.1).

Thus, reciprocity and social exchange are crucial for maternity protection support in formal and informal employment contexts, but tend to be played out differently. They influenced various aspects of employment relations including employer expectations, perceived trust and openness, and quality of relationships between employees and employer (or line managers in larger firms) and with colleagues. In rural areas this theme was also shaped by the level of poverty and associated hardship faced by affected women, as discussed below.

4.4 Livelihoods and self-employment

Although Ghana has achieved a comparatively high rating with respect to gender equality,⁴ related indicators are based on policies and are not necessarily translated into practice

⁴ The country's policies and institutional arrangements (CPIA), which is a diagnostic tool that measures key elements within the control of the country in 2012, rated Ghana's gender equality at 4 on a scale of 1 to 6 with one being the lowest. This rating is by the standards of the World Bank and although the rate is above average, the indicators which are more based on policies do not necessarily translate in the same way on the ground in implementation. The civil society in the country is quite concerned and for example, *ABANTU for Development*, a renowned credible gender and policy advocacy NGO in Ghana has raised issues with the Government of Ghana “to address the structural barriers that limit women and other vulnerable, and marginalized groups from benefiting equitably from the local economy” (Gender equality in Ghana's local governance system, 2014).

on the ground. In Ghana, women are over-represented in the informal economy⁵ and more likely to be self-employed than men (GSS, 2014).⁶ They therefore benefit less from social protection, as related schemes are mostly linked to formal employment. As a consequence, the poorest Ghanaians are overwhelmingly women (Tessier et al., 2013). The key issue in this theme is therefore that poor pregnant women often cannot afford to lose a day's wage to attend antenatal checks or to take any rest before giving birth. A common subject in our data was also that families either could not pay for the journey to the hospital or, if they made it to the hospital, could not afford the trip back to the village. We were also told by some interviewees, particularly in rural areas of the Eastern Region, that they would rather use a TBA or give birth by themselves (without any help) than go to hospital. These women argued that they were required to bring a whole list of items to the hospital (e.g. sanitary pads, mackintosh to cover the bed before delivery, baby clothes etc.) which were too costly for them. In addition, a self-employed food seller in the Eastern Region (SE-ER9) stated that she had feared birth complications which could lead to additional costs that were not covered by NHIS membership.

The same livelihood issues applied to maternity leave. The length of time off work after delivery amongst employees and self-employed women in the informal economy depended on their personal circumstances. In the informal economy, maternity leave for employees was unpaid in most cases (see Section 5.2.1). Since self-employed workers do not currently receive any paid maternity leave, the length of their time off from work after birth depended on their ability to draw on savings or financial support from their husbands or other sponsors. Amongst the self-employed, we found the longest leave periods in Accra, ranging between 1 month and 1 year, with women taking on average 3.5 months off.⁷ In the Eastern Region the women we spoke to provided the most varied account of leave taken. Although here self-employed women took on average 3 months leave after childbirth, there were also exceptional cases where women had taken 2 years in one case (SE-ER9) and no leave at all in another case (SE-ER10). A farmer and trader (SE-ER10) from the rural Eastern Region, explained that she could not afford to take more than a few days off after the birth of a child. As mother of five young children, she pointed out that pregnancy and maternity always had a considerable impact on their livelihood:

“During pregnancy and after birth I face terrible challenges combining that situation with my work because the nature of the job demands full activeness but I can't work enough so our productivity level drops drastically. The heat from the furnace also causes sickness for me most of the time. I always become weak easily and I cannot even go hawking some of the gari either. So that period of my life affects everything in the whole family. This is because we don't have supporting hands from anyone and we cannot afford to employ supporting hands”.

⁵ In Ghana, 88 per cent of the working population operate in the informal economy (GSS, 2014).

⁶ In Ghana, 47.8 per cent of females and 35.5 per cent of males (15 years and older) are currently employed in the private informal economy (excluding agricultural activities). Furthermore, 50.5 per cent of women are currently self-employed (own-account workers), compared to 41.9 per cent of men. The proportion of unskilled female workers involved in trading activities (45.4 per cent) is also higher than that of the male workers (40.3 per cent) (GSS, 2014).

⁷ Care needs to be taken not to generalise from these findings due to the relatively small sample size and as outliers have a strong effect on average leave periods.

The shortest average leave periods around childbirth could be found in the Upper East where the self-employed women interviewed took on average 2 months' leave after childbirth, with the majority of women in rural areas taking less than 2 months' leave. In our fieldwork villages in the Upper East we were told that it was common practice for women to return to work three days after delivery if having given birth to a boy and four days in case of a girl (FG-UE1; FG-UE2; SH21). These women then resumed their normal lives, cooking, carrying water and sometimes even working in the fields. It was explained to us at the Community-based Health Planning and Services (CHPS, SH21) that this posed severe risks to the health of both mother and baby, especially after a complicated birth. When asked about the reasons behind this practice, one of our focus group participants (FG-UE2) replied '*out of necessity we close our eyes*'.

The number of school-age children present during school hours in our fieldwork villages in the Eastern Region was striking. When asked about this, interviewees and other villagers explained that it was a common practice to withdraw older children from school so that they could look after younger siblings whilst the mother was at work. For instance, a farm worker and mother of five (EE-ER7) told us that her 7-year old daughter was left at home to look after the 1-year old sibling, while the twin brother of the 7-year old continued to attend school. Given the importance of education as a route out of poverty, such practices are problematic as they reinforce existing poverty cycles and especially disadvantage girls and women. In Accra, the vast majority of self-employed women in our sample brought their children to work until they had reached school age or sent them to a crèche if they could afford it. In the Upper East the provision of formal childcare for children under four years was extremely scarce.

As self-employed women and employees in the informal economy were unlikely to benefit from social protection packages,⁸ cultural traditions of gift giving helped mothers with essential goods, while community groups and self-help (such as associations or church) became important alternative sources of support (see Box 4.3). However, when discussing informal sources of funding, a recurring theme was lack of expertise and trust. Participants argued that it was difficult to find genuine people who could lead on such initiatives and not run off with the money. There is therefore a need to provide alternative financial support to those who do not benefit from cash payments to sponsor maternity leave, as set out in ILO Convention No. 103 [Article 4].

⁸ None of our participants had received LEAP. It may be that the study did not reach out to the poorest groups of the population. It may also be that LEAP had not reached the poorest of our participants. As mentioned in Section 2.2.2, at the time of the study it was estimated that LEAP was only reaching one sixth of the extremely poor. However, the study was not set up to investigate this issue further.

Box 4.3: Alternative sources of support**Church groups**

“When I give birth the women’s fellowship in my church which I belong to also provides support in cash and kind but it is just a one off support and not monthly. The church welfare committee also supports new mothers with a one-time donation of cash and kind and that is because I am a contributor to the welfare committee so I am entitled to that donation. Though it is not enough, we all appreciate it and manage it to purchase a few things for the baby” (university employee in Accra, EE-AC9).

“I am the secretary of the Women’s ministry in my church so I got support from the group when I gave birth to my baby in the form of cash amount of GH¢ 300 and some baby materials” (public servant in urban Eastern Region, EE-ER1).

Association of market traders

“We have a welfare system for our market women. They often spend their whole life here and, since there is no pension scheme for them, we make contributions to help them during social activities such as funerals, childbirth and weddings. When there are cases of malpractice amongst the market women we have measures; we could give advice, or fine the offender if necessary. We have put some arrangements in place, such as a microfinance system, so that the market women can save and also take loans to boost their businesses” (leader of market association in Accra, ER-AC9).

Cultural tradition of gift-giving after the birth of a child

“Almost all my colleagues presented me with gifts of soap, shea nut oil, clothes for the baby, pomade, OMO, and some even added a little cash” (weaver in urban Upper East, SE-UE12).

“Most friends gave gifts and helped with washing clothes, and some also gave clothes. Some of these were friends and some customers. When I delivered, a lady from Navrongo fried some millet and ground it. This helps to get breast milk for the baby” (hair dresser in urban Upper East, SE-UE5).

4.5 Access to health services for rural workers

As discussed earlier, for informal economy workers in remote rural areas, the community in which they lived tended to be their workplace. Given the often harsh living and working conditions in these contexts, and the very limited maternity provisions, access to qualified health care was the key issue identified by women interviewed in these contexts. This determined their propensity to register with the NHIS, to attend ante- and postnatal checks, and the likelihood of giving birth at hospital. Long distances and poor road conditions, lack of electricity, geographical barriers, lack of transport, poor communication infrastructure and associated costs (see also Section 4.3 on Livelihoods) all played important roles in determining accessibility to health care facilities and therefore maternal health outcomes. As discussed earlier (see Section 2.3), research suggests a strong relationship between poor transport organisation and high levels of maternal mortality (Grieco and Turner, 2005; Holmes and Kennedy, 2010; Masters et al., 2013).

In both the Upper East and the Eastern Region we were told by participants that NHIS registration often required women to take a whole day off from work. They sometimes had to walk 10 km to the next district town to register and, in several cases, women reported long queues by the time they arrived. In a few cases, this meant that they could not be seen that day and were asked to come back another time. In the Eastern Region one participant (food seller, SE-ER9) told us that women in the village would wait at the registration office overnight in order to be seen the following day. Particularly for those who were living in poverty and for whom each day of lost work resulted in difficulties in feeding their family that day, experiences of this kind deterred women from making a second attempt to register. One of the women (farm worker, EE-ER8) reported that she only managed to register with the NHIS when she was 4 months pregnant but that she had already given birth by the time she received her membership card. She therefore ended up paying for delivery at hospital.

The issue of long distances and poor infrastructure also applied to antenatal visits. Some of the women we interviewed reported that they had to walk 6 to 10 km to get to the nearest Community-based Health Planning and Services (CHPS) compound or clinic. In these cases, the likelihood of attending check-ups was reduced over the course of pregnancy, as it became increasingly difficult for them to make the tiring journey. Experience of a miscarriage in a previous pregnancy, or hearing from other women who had suffered a miscarriage, as a result of these exhausting walks further discouraged women from attending antenatal checks in remote rural areas (see Box 4.4). In fact, in a few cases, they only went once to register and did not return until seeking for help when in labour. For instance, in one village in the Upper East Region we were told by a health worker (SH16) that women had to cross a stream when walking to their antenatal checks. Whereas this was easy during early pregnancy, it became increasingly challenging as pregnancy advanced, discouraging many women from attending their antenatal visits closer to giving birth. In two villages in the Eastern Region we were told that health staff would visit the community once a week (SE-ER2) or once a month (SE-ER12) to offer a baby clinic to weigh babies and provide free vaccinations. However in our study, we could not identify any examples of antenatal checks being offered in the form of such mobile clinics.

We also found evidence for the ‘first two delays’, discussed in Section 3.2 (see Box 4.4). Especially in the Upper East region, where most workers in rural areas work in farming, participants reported that pregnant workers tended to work in the fields until going into labour. They then had to get from the field to the CHPS compound to inform the midwife. According to the accounts of health workers interviewed in the study, the first delay occurs when women take too long to take the decision to seek help at the CHPS or the clinic and their labour is at an advanced stage. In such cases, the labouring woman sometimes does not manage to reach the healthcare centre in time to give birth. At one of the CHPS compounds in the Upper East (SH21) we were given examples of women giving birth in the millet after their waters had broken on the way. The second delay is related to the very limited availability of transport and resources to pay for the journey to the hospital.

In addition, in relation to both the first and the second delay, cultural factors played an important role as, according to health workers in the Upper East (SH21), women were sometimes not allowed to make a related decision and occasionally needed to ask the husband (or another male relative) for permission to seek care or leave the village.

Box 4.4: Transport as Key Barrier to Health Care Accessibility in Rural Areas

“For antenatal visits I used to walk for about 8–10 kilometres to Akayonga Health Center (Bongo-Beo). I gave birth to my children at home due to the distant nature but I think the kind of pain I endure would have been minimal if I had given birth to them at the clinic. On the day of delivery we don’t have access to ambulance or even a motor bike. It is either you walk or your husband picks you with a bicycle, that is, if he has one” (farmer in very remote village in the Upper East, SE-UE8).

“I never visited the health centre before giving birth to my first son due to the fact that we had to travel all the way from the village (Bongo-Beo) to the regional hospital at Bolgatanga, the regional capital, to access the health care. It was my other three children that I was able to visit the clinic once a while before giving birth to them. We used to walk from the village to Bolgatanga. We normally start the journey from 5:00am to about 10:00am. This discouraged most of us because by the time you get to the hospital you are already tired. Another reason we were not visiting the clinic is that most women had miscarriages due to the long hour walk. So we prefer to stay home to see what faith has for us. It is very painful to lose a child you carried in your womb for months” (farmer in very remote village in the Upper East, SE-UE9).

“Yes, I went for antenatal but on the day of my delivery I suffered a lot because the taxi that was to take me to the hospital did not arrive on time. I delivered in the house, when the taxi arrived I was taken to the hospital to be examined and for the cord to be cut. The health workers asked me why it took me so long, when I told them it was the distance they sympathized with me” (stone breaker in remote village in the Eastern Region – the road is in a bad condition, has large pot holes and is washed out in places, and is difficult to access with a normal car, SE-ER16).

“The pains started at midnight and luckily one boy had brought a taxi home that night and was sleeping in the village so I was driven to the health check point with the TBA. The nurse was not around. They called the nurse and she refused to come, so the birth attendant from the village helped me deliver on the clinic veranda” (basket weaver and farmer in rural Upper East, SE-UE6).

The use of mobile phones was widespread, even in remote rural villages that had no electricity, and played a very important role with respect to logistical arrangements (e.g. informing the midwife or traditional birth attendant (TBA), organising transport), but often this was problematic. For example, in one remote village in the Eastern Region, pregnant women had saved the phone numbers of all car owners in the surrounding villages to use in case of an emergency. However, the situation was frequently complicated when the phone was not answered. It was explained to us in one of our focus groups (FG-UE2) in the Upper East that, where villages do not have electricity, mobile phones had to be charged in a neighbouring village and also that the network coverage was not always reliable. In addition, sometimes midwives returned to their own village between Friday night and Monday morning without anybody replacing them.

In less remote areas of the Upper East and Eastern Region), taxis were commonly used as a means to reach hospitals. However, as a taxi driver in the Upper East (SH26) told us, based on his own experience and that of colleagues, where taxi drivers had acted as ambulance, negative experiences made them reluctant to transport a woman in labour again:

“We are sometimes not able to help pregnant women in labour who are unaccompanied due to fear of excessive support requests. We are often asked several questions by the health workers which is time wasting for us, considering that we have to make sales for the owners of the cars we are driving. Other times you are required to pay some of the bills of the women you are helping. [Such experiences] have actually scared most of us away from taking unaccompanied pregnant women in labour to hospital or the health centre. Most of these women are also not able to pay us.”

In some rural villages in the Eastern and Upper East Region, motorized tricycles (typically referred to by participants as ‘motor kings’) had been provided by the Government to help with transport to hospitals. However, according to focus group participants (FG-UE1), health workers (SH22, SH2) and a community leader (SH20) in the Upper East, the driver (who could also be based in another nearby village) would often not answer the phone, especially during the night, or the tricycle was not fuelled when needed. The community leader (SH20) from the Bongo district told us about the consequences this had for a woman in her village:

“She had gone into labour and was in so much pain that she found it difficult to walk but she wanted to try and walk to the next nearby clinic. She couldn’t get hold of the people with the motorbike and couldn’t get to the clinic in time – she died.”

Especially under such circumstances, when transport to the health facility was unavailable, TBAs became the most important source of help. Particularly in the Eastern Regions we found that women in the rural areas often preferred to seek help from TBAs instead of going through the stress associated with trying to organise transport to the next hospital. Although we did not identify any examples in our sample, we were told by a health worker in the Upper East (SH21) that cultural beliefs which reject modern healthcare also played a role in women’s decisions to seek birth support from TBAs instead (see Section 2.3).

However, only one of the four TBAs (SH24) consulted as part of this project had received training from Ghana Health Service (GHS). The other three TBAs pointed out that they would welcome the opportunity to receive training from GHS. This would also help them to identify complications early on and avoid fatal delays in referring affected women to emergency obstetric care.

We identified a case of a mother of five (who was heavily pregnant with her sixth child) in the rural Eastern Region (EE-ER7), who had given birth to all of her children – including twins – at home, without the help of a TBA. She argued that, in her case, there was ‘no time for hospitals’ and she also did not see the need to seek support during birth, as her babies had always been healthy:

“My in-laws were around to help with the birth of my first two children, but they are dead now, so I managed the delivery of the other three all by myself. My labour is very fast, so there is no time for hospitals. (Did you know that you were expecting twins?) Yes, they told me at the hospital. (Were you not worried about giving birth unaided in this case?) They were the easiest ones [laughs]!”

Although in this case, mother and babies were well after the birth, in other instances the outcome may have been less fortunate, as illustrated by the case of the woman who lost her life in childbirth.

5. Examples of good practices and coping strategies, costs and benefits

5.1 Bundles of good practices and coping strategies

This section summarises current good practices and coping strategies identified in our sample, accompanying the journey to motherhood, from supporting antenatal visits to offering family-friendly practices. ‘Good’ practices included effective and accessible maternity protection practices which comply with and preferably extend labour law requirements. However, we also looked for practices that can support maternity in workplace contexts which operate outside the reach of regulation. These included, for example, breastfeeding support at work and effective approaches to managing absences, as well as general family-friendly (including child-care support) or flexible working practices. Coping strategies refer to the practices used by individual women to combine work and maternity where workplace supports were not available, insufficient or not directly addressing their support needs. The boundaries between good practices and coping strategies are often blurred. We found that legal requirements are not always implemented in ways that are good practice, whereas some coping strategies could be a basis for future good practice.

While the practices identified cover all 5 elements of maternity protection as set out by ILO (e.g. 2012a), they were most effective if provided in ‘bundles’, i.e. if a combination of these different supports was offered to employees. The provision of these practices was shaped by a number of contextual factors, including the size of the business, level of formality, geographic location (rural/urban), cultural traditions and expectations, as well as the five key themes introduced in Section 4 (awareness of maternity protection: the policy, legal and regulatory framework and beyond; gendered cultural norms, traditions and expectations; workplace culture and reciprocity; livelihoods and self-employment; and access to health services for rural workers). Below, we provide 17 examples of good practices as well as coping strategies across six key areas of support, covering employers and workers in both formal and informal workplaces, large businesses, SMEs and rural areas (see Box 5.1). Some of these practices were relatively common (e.g. paid breaks for antenatal visits), whereas others could only be identified in a few cases (e.g. paid maternity leave in the informal economy) or even a single case (formal childcare support at work), but provide valuable ideas or strategies that can be built upon.

Good practice and coping strategy examples could be found across regions and sectors, although some patterns could be identified with respect to types of support provided in different work contexts. The most striking theme was the difference between smaller businesses (mostly in the informal economy) and medium sized and larger businesses in the formal economy regarding provisions of legal entitlements and family-oriented support. For instance, whereas formal employers of more than 30 employees were most likely to offer statutory provisions in the form of paid time off for antenatal visits, paid maternity leave and paid breastfeeding breaks upon return to work, employees here often perceived these as less

Box 5.1: Examples of good practices and coping strategies**Health protection in the workplace****Ante- and postnatal visits****1. Giving employees paid time off to attend antenatal check-ups^{1,2,3,4}**

Most workers in the formal economy and also some employees in the informal economy could attend antenatal during their paid working time.

2. Informing employees and self-employed workers of the importance of antenatal visits to allow identification of complications early on^{1,2,3,4}

Some employers proactively encouraged their pregnant staff to attend antenatal check-ups. In some rural villages, outreach work (e.g. talks at church and durbars [community gatherings], video shows and drama) was undertaken by community health volunteers to inform of the importance of antenatal visits.

3. Overcoming transport barriers in remote rural areas^{3,4}

In some villages health staff would visit the community once a month to offer a baby clinic; the same could be done to provide a mobile antenatal clinic.

4. Promoting and facilitating registration with the NHIS^{1,3}

In large formal economy firms information on NHIS was easily accessible. NHIS registration had also been promoted and encouraged extensively in an informal market place in Accra. All of our interviewees here were NHIS registered.

Changing workload and type of tasks**5. Re-arranging the workload of staff during pregnancy^{1,2,3,4}**

For example, some employers reduced any heavy or manual tasks in the jobs of their pregnant employees or, where jobs involved travel, made sure they had to travel less or under more comfortable conditions. Some also continued offering this type of support after the staff member had returned from maternity leave to facilitate the combination of work and breastfeeding. In cases where women had to return shortly after giving birth, a re-allocation of tasks could also include less manual tasks to allow women to recover from birth.

Maternity/paternity leave and cash benefits**6. Paid maternity and paternity leave in formal economy^{1,2}**

Paid maternity leave of three months was widely available in formal economy businesses. Although there currently is no statutory provision for paternity leave, some of the larger employers also offered paid paternity leave of between 5 and 10 days and, in one instance, a small employer (20 staff) provided new fathers with 7 days' paid paternity leave.

7. Maternity leave with pay in informal economy^{2,3,4}

Although maternity leave allowances were a lot more restricted in the informal economy, a couple of employers provided paid leave at a reduced level, e.g. paying 100% of previous earnings for 2 months, or 50% of previous earnings for 3 months.

8. Affordable maternity absence management^{1,2,3}

Employers frequently reported covering maternity absence by spreading the workload within the team or using volunteers, interns or apprentices to cover. Some would spread more difficult tasks within the core team and delegate easier tasks to volunteers, interns or apprentices. Although this approach provides these new workers with valuable work experiences which increase their employability, we also acknowledge that this approach can be problematic and result in exploitation in cases.

9. Mutual support (cash and kind) through associations^{2,3,4}

Self-employed women and paid employees in the informal economy were often members of associations which would provide them with small funds and other support to help them manage their lack of earnings

during maternity leave. Membership of church groups which offered some support to new mothers was also very widespread. Although a helpful practice, these supports often consist of one-off donations or presents and cannot replace maternity cash benefits.

Employment protection and non-discrimination

10. Guaranteeing the right to return to the same position^{1,2,3,4}

Employees in the formal economy were most commonly given the opportunity to return to the same position after returning from maternity leave. The same applied to those workers in the informal economy who had been identified as loyal member of staff.

11. Recognising the need for equal opportunities and treatment at the workplace^{1,2}

Another point in favour of offering maternity and family-friendly support which was identified by employers was the human rights case for women to have equal rights at the workplace and equal opportunities for career advancement.

Breastfeeding

12. Paid breastfeeding breaks that work for the employee^{1,2,3}

Some employers recognised the importance of giving mothers the option to either leave early to breastfeed or take breaks in the middle of the day. For example, whereas women who had access to their babies during the day could breastfeed during breaks, those who did not, preferred a shorter working day to allow them to get back to their babies sooner.

13. Giving mothers the opportunity to regularly bring infants to work and providing supportive environments for women to breastfeed^{1,2,3,4}

This was a particularly common practice in the informal economy, where women often brought their infants to work with them, but could also be identified in some smaller businesses in the formal economy in urban areas as well as in some schools. A few employees in the formal economy had a maid or family member that would bring the child to work during breaks to facilitate breastfeeding near the workplace.

Childcare

14. Formal childcare support^{1,2,3}

One example could be found in the form of a crèche inside a market in the informal economy. Another example was provided by a large employer.

15. Informal childcare support^{2,3,4}

It was common practice in the informal economy to regularly bring small children under school age to work. In more formal workplaces, this practice was less common, but workers were sometimes allowed to bring children to work in emergencies or regularly when not disruptive (see Practice 13).

16. Making use of under-/unused community asset^{3,4}

In one case, a group of self-employed women used the veranda of their children's school after teaching had finished, allowing them to continue their work while their children could play in a safe environment.

Flexible and family-friendly working arrangements

17. Changing hours of work upon return (e.g. allowing to work part-time; flexible hours)^{1,2,3}

Working reduced hours (often at full pay) or part-time (at reduced pay) for a few months upon return from maternity leave was particularly common in the formal economy. However, some examples could also be found in workplaces in the informal economy.

18. Allowing workers with family responsibilities to work from home if possible¹

This option was available to a few mothers in skilled jobs in large businesses, but we did not identify any fathers with access to this option.

*Practices identified in large businesses ⁽¹⁾; SMEs ⁽²⁾; the informal economy ⁽³⁾; rural areas ⁽⁴⁾

family-friendly than those in smaller firms. Smaller firms, on the other hand, were often struggling to provide legal aspects of maternity protection, such as paid maternity leave, but were often much better at providing family-friendly practices, such as informal childcare support and opportunities for breastfeeding at work (see Box 5.4).

5.2 Different maternity protection measures and associated costs and benefits

In this section we discuss the patterns of good practices and coping strategies as well as costs and benefits of support in more depth and also provide a variety of examples. Although this study did not undertake a systematic cost-benefit analysis,¹ this section demonstrates that effective maternity protection can benefit employees as well as employers of all sizes.

5.2.1 The costs and benefits of paid maternity and paternity leave

Maternity leave in the formal and informal economy

Paid maternity leave of three months was widely available in formal economy businesses. However, we did identify two cases of smaller workplaces which paid maternity leave at levels below statutory requirements. One of these included a teacher at a private school in the urban Upper East (EE-UE2) who had only been paid half her salary during her three months maternity leave. The other case was provided by a small employer (ER-ER5), running a nursery in the Eastern Region, who stated:

“I know the Government says we should pay three months, but I can’t afford that; all I can do is two months and then employ a new teacher to cover the one on maternity. I will then keep the new teacher as it’s not fair to send her back when the other one returns from maternity”.

In the informal economy, maternity leave for employees was unpaid in most cases.² We identified two exceptions (both small restaurant owners) who provided paid leave at a reduced level, paying loyal staff 25 per cent of previous earnings (urban Upper East, ER-UE7) and ‘a small allowance’ (rural Eastern Region, ER-ER7), respectively. The most obvious reason for small firms not to pay for maternity leave, which is also illustrated by the case above, was that they could simply not afford it. We also identified attitudinal issues as reflected in comments like *“why should I pay somebody who does not work?”* (weaver in urban Upper East, ER-UE10). However, as the following examples will demonstrate, some indicative evidence suggests that the associated costs can be lower than expected and depend on reciprocity, as well as on how maternity related absence is managed.

¹ In small firms, maternity protection support is mostly provided informally and on a one-to-one basis, rendering cost-benefit analyses especially difficult (see Lewis et al., 2014).

² We identified one employee (EE-UE14, urban Upper East) who had received 6 months of fully paid maternity leave as she was the daughter of the employer.

Box 5.2: Affordable maternity absence management**Replacement of workers on maternity leave**

"I use internship programmes to cover maternity absence. My interns get an allowance and lunch subsidy. [...] They usually stay for 3 months and then go back to university. Some are recent graduates that use the experience gained at my company to apply for jobs elsewhere" (female business owner in Accra, formal, 100 staff, ER-AC3).

Sharing work assignments among co-workers during maternity leave

"Women get pregnant all the time, we are very baby friendly. [How do you manage their absence?]. Existing staff are moved around between different hotels to cover for absences - this allows them to widen their experience and learn. In addition, we use national service staff and interns" (hotel manager in Accra, formal, 100+ staff, ER-AC2).

Planning ahead for maternity leave

"We plan ahead to take care of [maternity absences]. Remember each class has two teachers, so the other teacher takes full control till they return" (director of private school in Upper East, formal, 10 teachers, ER-UE6)

"NGOs reliant on donor funding have restrictions on the proportion of staff costs they can apply for. Therefore costs of maternity cover cannot be included when applying for grants: "we don't have an avenue for sharing the costs of maternity. For bidding you can only have 10% of costs for overheads... if other things come up then you have to dip into our funds. It is not a balance or a fair thing". This NGO had therefore decided that they had to diversify their income sources and was generating its own income from selling fair trade products and generating a surplus that could be used for unpredictable expenditure such as maternity leave (NGO in the Upper East, formal, 20 staff, ER-UE2).

Managing maternity absence

For larger businesses, especially those which were part of multinational corporations, costs were less likely to pose problems that would put the survival of the company at risk. The key issue here was to manage absence, particularly with respect to finding maternity cover with the required skills and expertise. As a female small business owner (formal sector, 20 staff, ER-AC5) in Accra emphasised in this context, *"you need to plan ahead, babies are not born overnight! You have time to think about how best to manage the situation when the time comes"*. This employer had experienced five staff pregnancies since she had set up her business eight years ago. She spread out more difficult tasks evenly among colleagues when somebody was on maternity leave and easier tasks were given to interns (who were only paid a small allowance) who could learn and gradually take on more difficult tasks. If they excelled, they stood a good chance to be taken on as permanent staff, which was helping to grow the business. This and the examples provided in Box 5.2 illustrate that planning ahead can help to reduce costs of maternity cover even in the resource constrained context of small firms and therefore make maternity more affordable.

We acknowledge that the use of low paid/unpaid interns or apprentices to cover for maternity absences can be problematic and result in exploitation in cases. This approach can thus be regarded as a coping strategy rather than a good practice. However, the outcome of this approach very much depends on how it is managed. In tight labour markets, it provides these workers with valuable work experiences which may lead to employment in the respec-

tive organization, or increases their employability elsewhere. More research is thus needed to explore in more detail the conditions under which such practices can be regarded as 'good' in addition to affordable.

In order for such practices to be effective, they need to lead to positive outcomes for both employers and employees. It is important that managers/employers recognise staff concerns regarding their workload and avoid the reorganisation of tasks leading to resistance and reduced motivation among the existing workforce. A small restaurant owner (informal economy, 5 staff, ER-UE7) in the urban Upper East provided a good example of how to achieve 'unity' and mutuality instead of rivalry among the team by embedding a reciprocal relationship in the workplace culture. In her view, it was important that her staff acted as *"each other's keepers"*. As she argued, *"when someone is sick and there is no unity to cover their work then I would have to sack people when they are sick"* and the same applied to staff pregnancy. She thus ensured her employees understood that all hardworking staff would be supported by her during pregnancy and maternity. In turn, when a staff member was slowed down by her pregnancy, she made sure she was supported by colleagues:

"By helping that lady, it improves the kitchen, and they will see that madam will stand by them and not sack them. It has changed their mentality to know that they are secure and that, if they are in the same situation, they will not be left alone".

This example demonstrates how maternity management can be both affordable and effective, and thereby lead to positive outcomes for both employers and employees. In addition, it shows that learning how to manage maternity related absence can benefit employers more broadly, as related strategies can be transferred to other areas of staff management, such as sickness and other forms of absence.

Paternity leave in the formal economy

The provision of paternity leave is not currently a legal requirement in Ghana. Although it was available in a small number of mostly large businesses, it was not necessarily taken up. In our sample, we identified 4 large employers in Accra, a public services employer in the Upper East (EE-UE11) and one medium-sized employer in the rural Eastern Region (ER-ER5) that offered between one to two weeks (5-10 days) of paid paternity leave, and 2 small employers in Accra (ER-AC5; EE-AC9) that provided up to 1 week (5 and 7 days) of paid paternity leave. We did not find any examples of paid paternity leave in the informal economy. However, we could identify only 1 (ER-AC5) case in which paternity leave had been formally taken up, in this case by an employee in a small organization. As the employer stated (ER-AC5), *"I give men 7 days paid paternity leave. I had my first father last year and I have two expectant fathers at the moment."*

Employers who offered paternity leave mostly blamed cultural views for this lack in take-up for paternity leave. This employer argued that ignorance of entitlements (see section 4.1.2) also played an important role:

"[Our male employees] are entitled to 2 weeks of paternity leave but many of them do not know and therefore do not claim it. They can be better supported if they are educated to put away the cultural beliefs that do not help and accompany their partners for antenatal care to learn more about the support they can give at home. That way they can also ask for some time off or make arrangements to be supportive" (large employer in health sector, Accra, ER-AC1).

In response to this lack in take up of paternity leave, this employer was now planning to proactively inform his workforce of this entitlement, and also to raise awareness of the ways in which fathers could become more involved in bringing up their children. Although it is not clear why this employer did not inform his staff of the entitlement to paid paternity leave before, this case nevertheless provides a good example of an employer who is actively trying to shift persistent gender roles.

However, it is not only fathers who need to be convinced to take up workplace paternity supports. Prevalent societal cultural views on the role of fathers (see Section 4.2.2) could also generate lack of trust. Thus a small number of male and female interviewees, as well as focus group participants (FG-AC1) raised concerns about how fathers might use their entitlement to paternity leave, if this was to be legally introduced. As a female employee of a large firm in Accra argued, *“if [fathers] are socially oriented to support their partners, then it would work when their workplace gives them time off to support their partners, but if not, they will misuse any time given to them (EE-AC7).”*

In comparison to paternity leave, fathers were more likely to request time off in family emergencies. In our sample, such requests were more frequent in larger businesses and their approval often depended on the relationship with managers (EE-AC3; EE-AC5; EE-UE4; EE-UE9). Employers' approach to support for fathers' with family responsibilities depended on their attitudes to fathers' roles. Although this health sector employer from Accra (ER-AC12) was generally supportive of giving fathers time off for antenatal visits and in family emergencies, he could also see why other employers might be less supportive, as it could end up being quite costly for the business:

“Men are usually in the formal jobs and do not get permission easily to attend antenatal with their spouses so when they do accompany them and the health system wastes time [through long waiting times at the facility] they cannot attend such visits frequently.”

In contrast, a female large firm employee in Accra (EE-AC6), whose husband did not receive any support for fathers at work, argued that there was a business argument for supporting family-oriented fathers: *“If employers do not support fathers or grant them time off when needed, fathers have no choice but to make up other reasons for needing time off”*. In her view, this would, in turn, exert pressure on trustful employer-employee relationships.

Maternity leave coping strategies of the poorer self-employed

As discussed in Section 2.2, the overwhelming majority of women operating in Ghana's informal economy benefit less from social protection, as related schemes are mostly linked to formal employment. This was also supported by our findings. Self-employed workers had to draw on savings or financial support from their husbands or other sponsors. For those women who did not benefit from social protection packages, community groups and self-help (such as associations, church etc.) became an important alternative source of support (see Section 4.4). However, in Ghana, the self-employed and informal economy associations can be highly structured in their organization (Kabeer et al., 2013; Kanbur, 2009), as this example of an informal support system, described by the leader of a market association, demonstrates:

“We have a welfare system for our market women. They often spend their whole life here and since there is no pension scheme for them we make contributions to help them during social activities such as funerals, childbirth and weddings”.

Culturally embedded practices of providing new mothers with gifts (including e.g. toiletries, baby clothes, food and cash) were widespread and related customs could be found across all participant groups and regions. However, although a helpful practice, particularly for those who neither receive paid maternity leave nor have any savings to draw on, they are mostly one-off donations or presents and cannot replace maternity cash benefits. The dependency on these practices reveals the vulnerability of these women and the effect that motherhood can have on their livelihoods (see Section 4.4).

Nevertheless, cultural practices like this one could be built upon to improve workplace supports for maternity. It is notable that, as discussed in Section 4.3, despite the cultural embeddedness of mutuality and reciprocity, related behaviours were much less evident in formal (particularly in large organizations) than in informal workplaces (see also Lewis et al., 2014). The above example of the small restaurant owner (ER-UE7) demonstrates how mutuality, collegiate trust and reciprocity can be built within organizational culture. It also suggests the importance of initiatives which raise awareness of the benefits that could be gained by bringing such culturally embedded practices into workplaces.

5.2.2 The costs and benefits of family-friendly working conditions, health protection and non-discrimination

When asking workers about their experiences of work during pregnancy as well as after birth, answers included *difficult, hectic, stressful, tedious and tiring*. Our findings demonstrate the importance of family-friendly measures that make it easier for employees to combine work and family responsibilities (see Box 5.3). The fact that related maternity protection provisions are often the only support provided by those small employers who cannot afford to offer paid maternity leave shows that they do not need to be costly. On the contrary, we found that a considerable indirect cost can be created by the dissatisfaction of employees with the lack of family-oriented support received after return from maternity leave (see Box 5.4).

Benefits of support

Across employment contexts, both employers and employees pointed out the benefits of offering a family-friendly workplace, including high retention rates, increased staff co-operation, reduced absenteeism, improved motivation and performance, as well as relationships built on trust (see Box 5.3), as found in other national contexts (Lewis et al, 2014; Stumbitz et al., 2017). Another point in favour of offering maternity and family-friendly support, which was identified by two large employers, was the human rights case for women to have equal rights in the workplace (ER-AC5, ER-AC3).

Interestingly, small firm employees across sectors often argued that they showed their appreciation of family-friendly support (particularly flexible working hours, the ability to bring children to work and take breaks for breastfeeding) by being more motivated and loyal to the business (even if they had not received any paid maternity leave) whereas employees of larger firms (who had sometimes even received more than the statutory three months of paid leave) were frustrated by the lack of family-oriented support and complaining about stress lowering their productivity.

Box 5.3: Family-friendly working conditions - benefits of support**Increased productivity, relationships built on loyalty and trust, and reduced staff turnover**

“Yes, I am allowed to bring my child to work. The arrangement is that my child attends the same crèche [where I work] at a discount. I am allowed paid breastfeeding breaks; milk warmers, sterilizers, bottles, fridges and pumps are made available for all breastfeeding mothers. There is a room available for breastfeeding but it is not a dedicated breastfeeding room” (nursery assistant in Accra, formal, 10 staff, EE-AC10).

Her employer acknowledged the benefits of the additional workplace support she was providing to both the business and her employees as follows: *“[It] increases the productivity level at work because full attention is given to work. It also builds a good relationship between the employer and the employee and this builds trust because the worker feels cared for by the employer. Lastly it reduces labour turnover rate which can be very costly”* (director of nursery in Accra, formal, 10 staff, ER-AC6).

“It is better (to support pregnant women) than asking them to resign. There are also the costs of bringing in people, recruitment and their experience. When you train someone new then it is more costly. Work has to go on but you have to make women comfortable” (director of NGO in the Upper East, formal, 20 staff, ER-UE2).

Sustained/improved productivity

“The costs at the beginning [of my pregnancy] were the morning sickness so this costs a lot, especially if you are the only one in the office and so you might miss deadlines, so this subtracts from your work. My boss said I could work at home more and so meet deadlines, not be stressed and able to deliver. [...] [Upon return to work] I still worked as before [having children] and although I am part-time now, I still take work home and use my days off to work. I am paid less as I am part-time on fewer days but this allows me freedom to do other things” (private sector employee in Accra, formal, 8 staff, EE-AC8).

Improved motivation

“I am really grateful for the support I was given during pregnancy and as a new mother. It was extremely stressful and sometimes very tiring, so often I felt lazy to go to school but was compliant as no one would take over my class if I stayed at home. When I was pregnant too, I had less contact hours with the children because I was frequently becoming tired even after the tiniest of activities” (teacher at public school, formal, EE-UE12).

Costs of non-support

Nevertheless, larger businesses were often less likely to offer family-friendly measures than small employers, resulting in reports of reduced staff commitment, co-operation and motivation, as well as reduced productivity and increased staff turnover (see Box 5.4). In addition, they were also often characterised by a more individualistic work culture and limited mutual support among colleagues (see Section 4.3.3). An exception is provided by this public sector employee in the urban Upper East (EE-UE8), who praised the support received from her colleague:

“The workplace policy did not provide the opportunity for me to bring my baby to work [...]; [it] was actually hostile towards childcare. The policy was that children are not allowed anywhere near it. There was no designated area at work for the baby and no crèches nearby for me to leave the baby while I worked, coupled with the fact that it was far from my home. I had to plead with one of my colleagues that [lived] close to the [workplace] to leave the baby and the babysitter there and attended to the baby’s needs from work”.

Box 5.4: Family-friendly working conditions - costs of non-support**Reduced commitment, co-operation and motivation**

"I am not happy with [this lack of support] and yes, that has influenced my approach to work in that I work strictly to the rule and do not allow anybody to take my extra time off. For example, if they try to fix a meeting into my closing time I do not accept it because I must leave promptly at my closing time to pick my children from school and I will not allow another minute to be taken off my time. When my employers are not willing to go the extra mile for me, why should I go another mile for them?" (employee of multilateral organisation in Accra, formal, 100+ staff, EE-AC7).

Reduced productivity

"Working with a new baby is difficult because you can't concentrate, especially when you leave the baby at home, every now and again you are sneaking into the urinal to make a call and ask if the baby has eaten, if the baby is OK, if the baby is sleeping and all that. Such things sometimes make you as mother unproductive at work because your mind is totally divided. At work, I can't say I get support from my colleagues but sometimes within us we could arrange and take the workload of a less busy co-worker while she looks after the baby but it is not official. Mostly the support is from a house help I usually employ but my mother sometimes helps too. Leaving the baby with a house help has very little guarantee that your baby is in good hands but when it is my mother I am not worried at all" (private sector employee in Accra, formal, 100+ staff, EE-AC9).

Increased staff turnover

"This employer was providing paid maternity leave in excess of legal requirements, but no family-friendly supports upon the return to work. He complained about his female staff not returning to work after their leaves had ended. As he argued, "human resources are a problem. You try to train them well and then they run away so we have to get new staff. [...] I have had 4 pregnant but only 2 have come back. [...] If a woman is committed to the work then you want her back" (hotel manager in urban Upper East, formal, 40 staff, ER-UE1).

However, although this arrangement helped her to cope for some time, she stated that lack of employer support and the stress that this caused for her resulted in her looking for alternative job opportunities:

"This had a toll on me and I think it also cost the [employer] regarding time spent going to [my colleague's home] to feed or change my son's diapers etc. [...] You can also imagine the toll your absence would have on your other colleagues. [...] Due these challenges, I resigned and took an appointment in a health centre that was closer to my home when my son was 10 months old".

The issue of lack of supports outside statutory provisions was reported by most large firm employees. For instance, an employee of a large firm in Accra (formal, 1000 staff, EE-AC1) reported that she knew of several colleagues who had resigned shortly after their return to work due to lack of family-friendly supports. As she argued, *"staff don't feel loyalty is rewarded here"*. Examples like this also demonstrate that women working in skilled jobs in the formal economy have a higher sense of entitlement to support and more choice than those in the informal economy, as they are more likely to have opportunities to move around between jobs. This can have costly implications for employers. *These findings demonstrate that there is much to be learned by large employers with respect to offering additional support, which does not need to be costly, but can have considerable positive business outcomes.*

Box 5.5: Coping strategies on childcare arrangements and breastfeeding at work

“It was challenging to combine my job and taking care of the baby. I work full-time from 7.30am to 6pm and my employer does not provide mothers with any formal breastfeeding support. I employed the services of a caretaker for six months who would come to work with me and take care of the baby in my car outside while I was working. Then, occasionally, when I was less busy I went out and breastfed the baby” (finance sector employee in Eastern Region, formal, EE-ER1).

“We are not allowed to bring children to work. Those of us who live nearby go home to breastfeed during breaks (that’s what I did too). Those who live far away bring their maids or relatives who look after the children outside, so that they can also be fed during breaks” (teacher at public school in Upper East, formal, EE-UE1).

“I bring my daughter (1.5 years) to work and usually have her in class with me. Occasionally the Head Mistress takes her and other children if she is not too busy. My daughter is a very lively child and having her in class with me means that I cannot always focus fully. (What does the employer think about teachers bringing their children with them?). It is not very well received. We have all been asked to leave our children at home but this is not an option for most of us so we have to bring them. [...] Yes, I am still breastfeeding – I do this on a chair outside the school during break times” (teacher at public school in Upper East, EE-UE2).

“Yes, we are allowed to bring our children to work and we can bring a carer. Mum [her employer] has provided us with a shed where we are expected to sit and breastfeed our babies but mostly, when customers are not around or just a few, we can breastfeed them anywhere” (cook in urban Upper East, informal, EE-UE14).

SMEs on the other hand, would benefit from some form of state-funded financial support for maternity leaves and, more generally, the introduction of a system of maternity leave cash benefits funded by compulsory social insurance or public funds (ILO, 2014). This together with their flexible and family-friendly working arrangements could enable them to benefit from becoming employers of choice for new parents as, for example, illustrated by related research in Japan (Atsumi, 2007).

In addition, for rural workers who neither benefit from employer support nor social protection programmes, there can be fatal consequences. The costs of non-support can be expected to be considerable, particularly with respect to their health and, relatedly, their families and children as well as their ability to work and maintain their livelihoods. As a result, these women tend to be trapped in poverty with very limited transformative potential for themselves and their children.

5.2.3 The costs and benefits of breastfeeding and childcare support

The two key concerns from the perspective of employees, which can also affect business outcomes negatively, were the management of childcare and the ability to combine work with breastfeeding. Employees who were not allowed to bring babies to work were worried about the well-being of their children and found it difficult to focus, which had a negative impact on their productivity.

An important issue in large organisations was often that breastfeeding support was provided to adhere to the law, but with little consideration of the needs of the employee. However, the opportunity to breastfeed babies or express breastmilk in the workplace was very rare in

large formal economy businesses. In our sample, we only identified one large organization (EE-AC12), based in Accra, which provided a crèche on site (see Box 5.6).

In the formal economy, the most common practice was to attach the stipulated paid hour (and sometimes even two hours) for breastfeeding at the end of the day, so that new mothers could work reduced hours. However, most affected participants did not feel that this arrangement helped them to breastfeed exclusively, especially if it was not possible for them to access their child during working hours. The experience of this employee of a multinational company in Accra (1000 staff, EE-AC1) illustrates how lack of family-friendly support can lead to stress and dissatisfaction of employees and thereby negatively influence their productivity. Although she had received maternity leave beyond statutory entitlements (4 months), she raised concerns about the lack of family-friendly support provided. Babies were not allowed in the office and there was no childcare support despite generous office space. Staff had requested a crèche at or near the workplace on several occasions but this had not been granted. She emphasised that there was a clash between the Government encouraging exclusive breastfeeding for six months when there were only 4 months of maternity leave (she recognised that this was more generous than the legal provision). Her employer was offering reduced working hours upon return to work (without reducing the salary) to support breastfeeding mothers. However, as the employee argued, this provision met the needs of the employer, but not hers and those of her baby:

“Even a six hour shift is still too long for a 4 months old baby to go without a feed. So, I was forced to start bottle feeding at 4 months when I had to return to work. I tried to express milk for some time, but often did not manage to get enough milk for the day as I was rushing to work. Eventually I gave in and started using formula instead. I was finding it too stressful to combine work and breastfeeding”.

We only identified one employee of a large private sector firm in Accra who provided formal childcare support in form of a crèche on site (see Box 5.5). The pregnant employee (EE-UE12) praised the crèche system and commended the organization for making it *“easier for families to work with little worries about taking care of their babies”*.

In the informal economy, it was very common to bring children to work (particularly in rural areas but also e.g. in market places in urban areas) and to breastfeed whenever the baby needed a feed. The examples we identified could not always be seen as good practices, but rather ways of coping with lack of childcare provisions in and outside the workplace. Schools provided an important example of formal economy organizations that often provided informal support. Although it was formally not allowed for teachers to bring children to work regularly, this was strictly enforced in some schools but not in others (see Box 5.5). A few public sector employees among our interviewees had a maid who would bring the baby to work, so that they could feed their child e.g. under a tree outside (e.g. hospital worker (EE-UE4); teacher (EE-UE1). Some mothers had the support of their extended family members, usually older women like their mothers or aunts, while others resorted to young children (as in the case of the 7-year old girl twin; see Section 4.4), other older women or domestic workers.

Most mothers who were interviewed found childcare on the whole expensive either in cash or kind. The option to send babies to crèches from a very young age (e.g. 3 months) was commonly available among workers in the formal economy in urban areas like Accra. In rural

areas such facilities were extremely scarce. Most mothers would therefore have welcomed a crèche at the workplace or nearby that would allow them to see their children and breast-feed during breaks. Related comments included that they would be more productive, as they would have to worry less and therefore be less distracted (employee in small law firm, EE-AC8), and would spend less time on breaks for breastfeeding (health worker in large organization, EE-UE8).

Although mothers who could bring their babies to work were more satisfied overall and were most likely to breastfeed exclusively for at least six months (among informal economy workers it was common to breastfeed for 1.5 to 2 years), such arrangements often became more difficult when babies turned into toddlers. Those who could bring their children to work often found it disruptive to look after their children while trying to work at the same time. In such cases there were also sometimes health and safety implications for the children, for example, if the workplace was a kitchen with open fires (ER-UE7; ER-ER1), or if the mother was working next to a busy street (ER-UE10). As in the case of those mothers who did not have the opportunity to bring their children to work, this could influence productivity negatively. As an example of good practice, a market (informal economy) in an urban area had responded to such challenges by setting up a crèche inside the market, which was used by its women traders and catered for children aged 1.5 to 5 years.³ Box 5.6 provides further examples of good childcare provision practices and coping strategies in the formal and informal economy that we found in our sample.

As discussed in Section 4.2.2, mothers' expectations of fathers' involvement in childcare were limited in most cases. However, a good practice example of rewarding fathers for their involvement in childcare could be found in a private school in Accra:

"Some fathers bring their kids to school when their mothers are sick, other fathers also don't even know where their children go to school. So sometimes during Speech and Prize Giving days we give prizes to such fathers because it is unusual. That is done to show appreciation and encourage fathers to support their children" (head teacher at private school in Accra, 16 teachers, ER-AC9).

Initiatives of this kind do not merely reassure those fathers who are already involved in childcare by presenting them as role models, they help to encourage other fathers to become involved in active fatherhood. They can thus be very powerful in shifting gendered societal views on the role of fathers and mothers.

³ Absence from duty due to pregnancy and confinement shall not affect the annual leave entitlement of a worker [Act 651, Article 22].

Box 5.6: Childcare provisions in the workplace

Crèche inside market in Accra (informal, ER-AC9)

This crèche was used by women traders in the market and catered for children aged 1.5 to 5 years. It was provided by the association of market traders and funded through the market association (membership fees, fines, etc.). The school was employing 16 teachers. The fee was kept low at GH¢ 15 per month to make it as affordable as possible.

Small business in Accra (formal, 20 staff, ER-AC5), offering informal childcare arrangement at the workplace

“We have a dedicated play area in the office for children from the age of two. This facility is even used by a woman working for a company nearby that does not provide any childcare support – the mother drops her child off after school and goes back to work”.

Private financial organization in Accra (formal, 120 staff, EE-UE12)

“The organization has a crèche just behind the main office where they take babies in after the mothers resume work after maternity leave from 3 months till toddler age of about two years when most parents take them to nursery schools and they also offer after school care services so that older children beyond the age of those in the crèche are cared for after school until their parents leave work and pick them. The crèche is under the care of a retired nurse and one professional nursery teacher and they also have two attendants who assist in the care of the babies”.

Small employer in Upper East (informal, 5 apprentices, ER-UE9)

The employer as well as her apprentices were bringing their babies and children to work. Older children were going to school nearby and would come after school to help looking after their younger siblings.

Group of self-employed women in Upper East (informal, SE-UE6)

These women with children were getting their livelihoods from weaving baskets. They were struggling to find a sheltered place to weave where they could also look after their children. They are now using the veranda of the school when it is closed to weave under cover, while the children can be in the school playground.

Teacher at public school (formal, EE-UE12)

“What we the female teachers in the school with babies currently do is that we bring mats to the school and when your child is sleeping, you leave him/her in the common room for the staff while you go to teach. Those teachers that wouldn't have a class during that period look after them while we teach but when they are awake we go with them (children) to the class”.

6. Conclusions and recommendations: Policy, interventions and further research

6.1 Recommendations

This short study has identified a range of challenges, coping strategies and good practices. We are also able to present some recommendations for the Government of Ghana, ILO, other donors, civil society organisations and businesses. These recommendations have been developed through consultation with stakeholders and drawing on the findings of the research. Throughout this process, attention has been given to identifying both the outcomes required and the appropriate means of reaching these outcomes. With the current constraints on public expenditure and the resources available to employers, some actions may take longer, and some desirable actions may not be possible. We are also sensitive to the nature of regulation enforcement in Ghana and the dominant role of the informal economy.

6.1.1 Awareness of the policy, legal and regulatory framework

This study has identified a key role for ILO and other agencies in raising awareness of the policy, legal and regulatory framework as well as good practice in supporting pregnant employees and employees with family responsibilities.

Recommendation 1. It is recommended that specific campaigns are developed for each segment (large employers, small businesses, self-employed and wage and salaried workers in both the formal and informal economy), ensuring that the approach is targeted and appropriate. Traditional leaflets and posters are less likely to be successful than more innovative use of a range of existing types of media, whenever this is possible.

Employers need to be conversant with the labour laws on maternity protection themselves and to raise awareness of these labour laws, combined with the business case for investing in staff. There is a need for very different approaches for employers using formal contracts and small employers in the informal economy. Attention should also be given to public sector employers as well as civil society organisations and even donors as employers themselves, so that they pay attention to measures that ensure maternity protection in their own organizations and workplaces.

For women wage or salaried workers, there is a need to raise awareness of rights and duties and to enable greater access to legal systems where necessary. Women's and their family members' awareness of the importance of having antenatal clinic visits early in pregnancy as well as taking adequate rest before and after delivery are also important.

Schools, colleges and universities are involved in delivering training on leadership and entrepreneurship – this can be adapted to include elements of good leadership that promote good practice in human resource management and maternity protection.

Business associations are vibrant and effective channels of working with small businesses (and self-employed) in urban areas of Ghana. They can be a forum to gather businesses in one place to receive training on good practice with respect to maternity protection and managing absence (related practices can also be applied to cover for sickness related absence). Attention should also be focused on the business case for retaining and supporting employees. There is a need to build the capacity of existing trainers (such as the National Board for Small Scale Industries) so they can cover issues related to maternity management in small businesses in an engaging way.

There is a diverse range of media outlets that can be used to raise awareness of maternity protection issues and, relatedly, challenge cultural expectations and gender roles. These include radio phone-in shows, TV programmes related to health, opportunities for awareness programmes to buy air time, TV dramas and 'Ghallywood' films that could be persuaded to have relevant story lines supporting awareness of maternal health issues, including with a particular emphasis on the need for maternity protection in the workplace. Popular theatre and theatre for social change, as well as traditional music, can play an important role and be used to raise awareness at local durbars [community gatherings] and other events, particularly with respect to reaching groups with low literacy rates. Social media can also play a growing role for those with access.

ILO and other UN agencies working on health issues could support a Maternal Health Awareness Day across the country, similar to the Farmers Day celebration, which can also address the need for maternity protection in the workplace. This could include award ceremonies, broadcast on television, for the best large firm, best small firm, best public sector employer (as well as recognition for the best taxi driver, best midwife and best father). The focus should be on creating an entertaining spectacle and raising awareness of the possible good practice that others can follow.

6.1.2 Maternity leave

While maternity leave is available to those in the formal economy, the majority of wage and salaried workers are in the informal economy. Improved access to maternity leave is expected as businesses grow and become more formalised. Presently there are considerable constraints on the growth of firms, which is reflected in the relatively small proportion of medium sized businesses in comparison to small firms. Support to help firms grow, and manage larger workforces, are expected to help improve access to maternity leave. However, the fact that maternity leave is the responsibility of the individual employer instead of collectively funded social insurance, constitutes a barrier for the further growth of formal employment, especially for women.

Extending maternity leave beyond three months would have health benefits for those who can retain their jobs. However, as long as employers continue to carry the full cost of maternity cash benefits, businesses may feel that they cannot afford such support, which is likely to lead to greater discrimination in recruitment of women of childbearing age.

Recommendation 2. Although Ghana should aspire to ratify ILO Convention No. 183 (requiring a minimum of 14 weeks maternity leave), improving and extending maternity leave is only possible if the Government is able to establish a contributory social insurance scheme funding maternity leave benefits or to cover all or some of the costs through tax-revenue based direct payments or tax relief and incentives. It is recognised that this may be unlikely

in the current context. Maternity leave could be extended following the commitment to cover the full or extra costs by social insurance or public funds. In addition, guaranteeing income security for women in the informal economy should also be among the priorities, for instance, through the improvement of the coverage and sustainability of the LEAP programme and/or the inclusion of maternity protection in public works programmes (ILO, 2015).

Recommendation 3. Maternity leave is more likely to be granted and the business case for offering maternity leave is stronger when there are effective and cost-efficient ways of covering absence. Two examples of good practice are identified. Firstly, employers can focus on building team loyalty within businesses, so employees take on extra responsibilities of their colleagues who are on leave. This can be supported through training and publicizing examples of good practice. Secondly, the use of fixed-term workers (including apprentices and interns) was also documented and can provide cover, while also providing training opportunities for future employees. For instance, more difficult tasks are spread among colleagues and easier tasks are given to apprentices/interns who can learn and gradually take on more responsibility. Public employment services can be encouraged to support businesses in identifying potential cover through established traineeship/internship programmes.

6.1.3 Health protection at work

Hospital based reviews in Ghana in the past several years are showing a change in the cause of maternal mortality to be shifting from haemorrhage, which used to be the leading cause, to pregnancy induced hypertension. One of the major causes of hypertension is stress shaped by working conditions. In Ghanaian Labour Law there also currently is no requirement to undertake a workplace risk assessment and to prohibit work prejudicial to the health of the pregnant or nursing mother and her child. The greatest risks of maternal mortality and morbidity are found amongst the self-employed poor who are not able to afford time off for antenatal check-ups, maternity leave or childcare and cannot cover transport costs.

Recommendation 4. In order to ensure that the health of pregnant or nursing workers and their child is not put at risk, there is a need to identify any potentially dangerous work or harmful working conditions, eliminate the risk, adapt the working conditions or, if the latter options are not possible, to temporarily transfer women workers to another kind of work not prejudicial to their health without loss of wages (as stipulated by Recommendation No. 95 (5)).

Recommendation 5. Supporting livelihoods of the poorest is also crucial for maternity protection and ensuring the self-employed have access to health services. The greatest risks of maternal mortality and morbidity are found amongst the self-employed with low income who are not able to afford time off and/or direct costs for antenatal check-ups, skilled delivery, maternity leave or childcare and cannot cover transport costs.

There is also a need to support women's enterprises, encourage access to markets and supporting growth. This could be done through training, peer learning, and support for intermediaries who will create markets, and could e.g. be facilitated by NGOs in collaboration with association leaders.

Recommendation 6. Health protection at work for the self-employed and informal economy workers requires specific awareness programmes. These can be focused on chiefs, queen mothers [traditional community midwives], elders, head teachers, parent teacher associa-

tions, churches, and mosques. The use of mobile cinema vans and stage play in remote and rural areas is one concept that can be explored due to its high success in awareness creation in such communities.

To support the self-employed, there is a need to raise awareness of maternal health issues, particularly amongst men in rural areas where there are traditions of restricting women's decision making regarding accessing health and travel outside of communities.

Recommendation 7. Mobile antenatal care, similar to models of monthly baby clinics, can help identify complications early, and reduce the costs of transport and time off work. This could also help to address the issue that women were increasingly less likely to attend antenatal visits as they got closer to the time of delivery which is the crucial period when pregnancy induced hypertension is more likely to be detected. These mobile clinics can use existing community facilities on a monthly basis but would require funding for the fuel and transport costs of nurses and midwives. NHIS registration could also become available more widely, at public places (such as school, post offices, hospitals and health centres, etc.), online or through mobile phones to reduce waiting times at facilities. In order to also include those with limited internet access and illiterates, NHIS registration could be made available during mobile antenatal and baby clinics.

6.1.4 Cash and medical benefits

Fully paid maternity leave as a statutory requirement is only found in the formal economy, with the informal economy only providing some cash payments at the discretion of the employer. There are no government or social security maternity cash benefits. Regarding medical benefits, employees in the formal economy are supposed to be enrolled in the NHIS, and some employers may also offer complementary health coverage. However, employees in the informal economy and self-employed workers interviewed, particularly in remote rural areas, did not have access to medical benefits, mostly due to the distance to the facilities where registration took place.

Recommendation 8. The self-employed are found to have the least access to maternity leave. The poorest self-employed people, including households benefiting from the LEAP programme, should be entitled to direct payments to help them cover the costs of lost work and transport to health services. Where the poorest (self-employed and employees) cannot afford the time off and transportation costs for maternal health services, additional cash transfers through the LEAP programme can be considered.

Recommendation 9. Transport is a major constraint on women's access to health services, particularly for the rural self-employed that live even short distances off main roads. Traditional Birth Attendants also continue to play a crucial role in getting women to health services or in providing obstetric care where transport is not available. They would therefore benefit from training by GHS to help them to provide the best possible emergency care.

Taxi services usually offer the only alternative for women in these locations. Opportunities for vouchers for taxi or other commercial vehicle fares (to and from antenatal care and during labour/after giving birth) could be explored with the poorest women, such as those involved in the LEAP programme. This also requires first aid and providing emergency transport for the sick by ambulance, and to ensure taxi drivers are not penalised for bringing women to health services without the means to pay for health services.

6.1.5 Employment protection and non-discrimination

Good practice in terms of ensuring employment protection for pregnant women and workers with family responsibilities, and building workplace loyalty have been identified. This is a crucial element in providing a business case to employers to invest in their staff, improving working conditions and improve levels of quality and productivity in the long term. There is a particular need for employers to support employees during pregnancy, allowing staff to comfortably disclose their pregnancy, attend check-ups and have an adjusted workload, without the risk of losing their job. This is partly an issue of awareness raising (discussed earlier).

Recommendation 10. Training programmes on good practice in managing maternity and the business case should be included in the extra courses related to leadership and entrepreneurship currently being delivered or planned in schools, colleges and universities. Examples include short courses for all students as future leaders of businesses (large and small), on starting and managing businesses, and on growing businesses which should provide a basic understanding of the definition and need for maternity protection at the workplace.

6.1.6 Supportive workplaces for breastfeeding

Ghana demonstrates much good practice with respect to encouraging exclusive breastfeeding for the first 6 months of a baby's life and adequate breastfeeding thereafter until the child is weaned, particularly in the informal economy. Formal economy businesses were found to be much less supportive due to less opportunity for mothers to take frequent breastfeeding breaks, or bring their children into the workplace to be fed. Provision of breastfeeding support appears to be more common in smaller firms as it usually involves little or no costs. Businesses can benefit directly through increased staff retention and enhanced staff commitment and indirectly from the well documented advantages of workplace breastfeeding supports on the health of women and children, including reduced absenteeism.

Recommendation 11. All employers, especially those in formal businesses and the public sector should be encouraged to provide more support to mothers with codes of conduct supporting breastfeeding arrangements that work for the employee, and maternity-friendly spaces provided for breastfeeding and related working time arrangements.

6.1.7 Family-friendly working and childcare

Improved access to childcare at or close to the workplace, teleworking arrangements and other support measures can assist breastfeeding and work-family reconciliation, allow staff to work more productively and help women stay in the labour market.

Recommendation 12. Provision of accessible, adequate and affordable childcare services and pre-primary education should be a priority. Support to private and social enterprise nurseries can come through specific training programmes and financial support that encourages childcare enterprises offering quality and affordable services to be set up and grow. Support can also be focused on social enterprise models of childcare owned by communities, cooperatives or associations of self-employed. These enterprises and initiatives can be supported through encouraging peer learning, using existing examples to demonstrate to those starting up, providing model constitutions and policies for enterprises, or funding interns/placements for those wanting to start in successful examples.

Childcare can be supported through better use of existing community spaces and facilities such as community centres, town councils and churches. Several small employers in the same geographic location can get together in providing affordable and practical childcare solutions or, alternatively, be given access to the childcare provisions of larger employers.

Crèches within market places can be supported through the provision of shelters and secure settings for babies and young children. There is the potential to seek funding for the construction from corporations wanting to have an advertising presence within markets, and wanting to demonstrate their corporate social responsibility. There is a need to raise the quality of provision through adequate training of carers.

6.2 Future Research

Research on maternity protection in Ghana as in other developing countries is scarce. Research on maternity care rarely takes account of employment factors while research on employment rarely considers maternity issues. This study is therefore important in opening up the research agenda to consider how women can be supported during pregnancy and childbirth while also earning a living and contributing to Ghanaian economic development. The findings from this study suggests a number of possible future research directions to address problems of maternal and child health and ultimately to develop the Ghanaian female labour force. Research is needed to explore ways of fostering and monitoring changes in employer practices, as well as in relation to health care provision, access and take up (including with respect to social protection initiatives such as the NHIS and LEAP 1000).

Basic research is necessary to ensure that questions about the feasibility, practice and outcomes of maternity protection in SMEs are on research agendas in Ghana and how this relates to use of maternal care services – for example how employers can help to ensure that women access antenatal care.

Small business owners, including employers in both the formal and informal economy, are most likely to develop effective maternity protection practices if these can be seen to involve no costs and if positive business outcomes are expected. There is some evidence from this project to suggest that small changes in practices to support pregnant women and new parents can be feasible. Ethnographic and action oriented research is needed to help employers evaluate and if possible measure positive outcomes of such practices in order to begin to reframe maternity provisions as a business strategy as well as an issue of social responsibility. Positive outcomes are always difficult to conceptualise and even more difficult to measure, but may include, for example, healthier and more motivated workers who are able to work better or to develop new skills, less sickness absence or loss of experienced workers through illness (or death), a more cohesive workforce and better team work, etc. It will be important to work with employers to encourage them to identify the nature of positive outcomes and think about how they would recognise and assess productivity in their own specific context. This may be easier to do in manual work than in other forms of work and vary by sector. However, this should be part of a collaborative reflective process and not rely solely on the evaluation of outcomes by (owner-) managers, who tend to be partial and biased observers (Lewis et al., 2014). It is recognised that targeting informal employers will be particularly challenging and will call for innovative ethnographic approaches.

As any good practices and/or positive outcomes will be very context specific, varying by cultural context, regions, different, types of work, etc., it would not be possible to identify generic recommendations. Rather the research would focus on identifying the processes whereby mutually beneficial practices can be identified and used to change owner- manager attitudes to maternity protection. This research could also involve NGOs or others familiar with the businesses.

In formal SMEs and larger organizations where maternity protection policies are implemented, research is needed to examine how this works in practice, including level of take-up and to identify the conditions under which it is most effective in terms of safeguarding women and also benefitting organisations, perhaps via reciprocity and social exchange.

Qualitative research will be needed in communities to evaluate the feasibility and outcomes of pilot experiments to support maternity and the return to work in remote rural contexts, for example, the suggested systems regarding taxis, stage play discussed above and community-based childcare initiatives. It would be good to involve employers in this research and to try to identify ways in which employers and community based workers can work together.

Research is needed to identify the skills needed by both employers or managers and employees to be able to engage in effective dialogue, to make their needs known and to respect the needs of the other, in order to collaboratively design creative solutions.

Finally, research is needed with a specific gender dimension. Men are needed to support women through maternity and to help raise children. Cultural constructions of masculinities in parts of Ghana can be viewed as undermining men as well as women. Research is needed to explore fathers' experiences of fatherhood and masculinities in order to inform campaigns or interventions aiming to provide men with a wider range of options and role models in relation to masculinities. The impact of experimental interventions developed from such research could then be assessed using pre- and post-intervention measure scales. This approach has been used, for example, in a pilot intervention to promote gender equity among young men from low-income communities in Mumbai, India and was successful in shifting key gender-related attitudes (Verma, et al., 2006).

6.3 Conclusion

This report has explored maternity protection in various different forms and sizes of enterprise in Ghana, a country with high rates of maternal mortality. Apart from the level of statutory provision, actual access to maternity protection measures was found to be shaped by a number of contextual factors, including employment characteristics and the wider cultural context (e.g. norms, traditions and expectations with respect to gender roles) which in turn influence the workplace culture (e.g. attitudes of business owners and line managers with respect to support) and employees' sense of entitlement (influencing what employees feel is fair to expect or ask for), as well as processes of reciprocity. Thus, maternity protection practices vary immensely, sometimes reflecting maternity rights at work as set out by national legislation, but not necessarily meeting women's needs (particularly in large organizations); often falling short of legal entitlements (particularly in the informal economy) but at times also going beyond them in some respects.

Regulation is essential to protect the lives and health of new mothers and young children, but it is clearly not sufficient. It covers a minority of women workers as it is poorly enforced, unaffordable for most small business owners, particularly paid maternity leave that is funded entirely by employers, and beyond the reach of those working in the informal economy. The limited maternity support employers can provide for their employees is thus often driven by their own vulnerability. In order to facilitate more successful maternal health outcomes of the SDGs than those achieved by the MDGs, the findings indicate the need for a multi-pronged, context sensitive approach to maternity protection that includes regulation, awareness raising initiatives, information and guidance for informal supports, alongside formal policy and encouragement of local community initiatives.



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Appendix I: Overview of Ghana Labour Act, 2003 (651) Maternity protection provisions and gaps

	Labour Act, 2003 (Act 651)	Maternity Protection Convention, 1952 (No. 103) and related Recommendation No. 95	Maternity Protection Convention, 2000 (No. 183) and related Recommendation No. 191	Convention on Workers with Family Responsibilities, 1981 (No. 156)
Maternity Leave Duration	At least 12 weeks in addition to any period of annual leave ¹ she is entitled to after her period of confinement [Article 57 (1)].	At least 12 weeks [C103, 3 (2)]. <i>The maternity leave provided should be extended to a total period of 14 weeks where necessary to the health of the woman and wherever practicable [R95, 1(1)].</i>	At least 14 weeks [C183, 4 (1)]. <i>Members should aim to extend the maternity leave period to at least 18 weeks [R191, 1 (1)].</i>	
Leave in case of illness or complications	The period of maternity leave may be extended for at least two additional weeks where the confinement is abnormal or where in the course of the same confinement two or more babies are born [Article 57 (3)]. Where an illness, medically certified by a medical practitioner, is due to her pregnancy or confinement, the worker is entitled to additional leave as certified by the medical practitioner [Article 57 (4–5)].	In case of illness medically certified arising out of pregnancy or confinement, national laws or regulations shall provide for additional leave before confinement, the maximum duration of which may be fixed by the competent authority [C103, 3 (5–6)]. <i>In individual cases and on the basis of a medical certificate, a further extension of the ante-natal and post-natal leave [...], if such an extension seems necessary for safeguarding the health of the mother and the child, and, in particular, in the event of actual or threatening abnormal conditions, such as miscarriage and other ante-natal and post-natal complications [R95, 1 (2)].</i>	On production of a medical certificate, leave shall be provided before or after the maternity leave period in the case of illness, complications or risk of complications arising out of pregnancy or childbirth. The nature and the maximum duration of such leave may be specified in accordance with national law and practice [C183, 5]. <i>Provision should be made for an extension of the maternity leave in the event of multiple births [R191, 1 (2)].</i>	

Labour Act, 2003 (Act 651)	Maternity Protection Convention, 1952 (No. 103) and related Recommendation No. 95	Maternity Protection Convention, 2000 (No. 183) and related Recommendation No. 191	Convention on Workers with Family Responsibilities, 1981 (No. 156)
Compulsory leave before and after confinement	Not specified. The period of compulsory leave after confinement shall be prescribed by national laws or regulations, but shall in no case be less than six weeks; the remainder of the total period of maternity leave may be provided before the presumed date of confinement or following expiration of the compulsory leave period or partly before the presumed date of confinement and partly following the expiration of the compulsory leave period as may be prescribed by national laws or regulations [C103, 3 (3)]. The leave before the presumed date of confinement shall be extended by any period elapsing between the presumed date of confinement and the actual date of confinement and the period of compulsory leave to be taken after confinement shall not be reduced on that account [C103, 3 (4)].	With due regard to the protection of the health of the mother and that of the child, maternity leave shall include a period of six weeks' compulsory leave after childbirth, unless otherwise agreed at the national level by the government and the representative organizations of employers and workers [C183, 4 (4)]. The prenatal portion of maternity leave shall be extended by any period elapsing between the presumed date of childbirth and the actual date of childbirth, without reduction in any compulsory portion of postnatal leave [C183, 4 (5)]. <i>To the extent possible, measures should be taken to ensure that the woman is entitled to choose freely the time at which she takes any non-compulsory portion of her maternity leave, before or after childbirth [R191, 1 (3)].</i>	
Cash and Medical Benefits	See below. While absent from work on maternity leave in accordance with the provisions of Article 3, the woman shall be entitled to receive cash and medical benefits [C103, 4 (1)]. Medical benefits shall include pre-natal, confinement and post-natal care by qualified midwives or medical practitioners as well as hospitalisation care where necessary, freedom of choice of doctor and freedom of choice between a public and private hospital shall be respected [C103, 4 (3)].	Cash benefits shall be provided, in accordance with national laws and regulations, or in any other manner consistent with national practice, to women who are absent from work on [maternity] leave [C183, 6 (1)]. Each Member shall ensure that the conditions to qualify for cash benefits can be satisfied by a large majority of the women to whom this Convention applies [C183, 6 (5)]. Medical benefits shall be provided for the woman and her child in accordance with national laws and regulations or in any other manner consistent with national practice. Medical benefits shall include prenatal, childbirth and postnatal care, as well as hospitalization care when necessary [C183, 6 (7)].	

Appendix I: Overview of Ghana Labour Act, 2003 (651) Maternity protection provisions and gaps (*continued*)

	Labour Act, 2003 (Act 651)	Maternity Protection Convention, 1952 (No. 103) <i>and related Recommendation No. 95</i>	Maternity Protection Convention, 2000 (No. 183) <i>and related Recommendation No. 191</i>	Convention on Workers with Family Responsibilities, 1981 (No. 156)
Amount of maternity cash benefits	100% of previous earnings and other benefits to which she is otherwise entitled [Article 57 (2)].	The rates of cash benefit shall be fixed by national laws or regulations so as to ensure benefits sufficient for the full and healthy maintenance of herself and her child in accordance with a suitable standard of living [C103, 4 (2)]. Where cash benefits provided under compulsory social insurance are based on previous earnings, they shall be at a rate of not less than two-thirds of the woman's previous earnings taken into account for the purpose of computing benefits [C103, 4 (6)]. <i>Wherever practicable the cash benefits to be granted should be fixed at 100% [R95, 2 (1)].</i>	Cash benefits shall be at a level which ensures that the woman can maintain herself and her child in proper conditions of health and with a suitable standard of living [C183, 6 (2)]. Where, under national law or practice, cash benefits paid with respect to leave referred to in Article 4 are based on previous earnings, the amount of such benefits shall not be less than two-thirds of the woman's previous earnings or of such of those earnings as are taken into account for the purpose of computing benefits [C183, 6 (3)]. Where, under national law or practice, other methods are used to determine the cash benefits paid with respect to leave referred to in Article 4, the amount of such benefits shall be comparable to the amount resulting on average from the application of the preceding paragraph [C183, 6 (4)]. <i>Where practicable, the cash benefits to which a woman is entitled during leave referred to in Articles 4 and 5 of the Convention should be raised to the full amount of the woman's previous earnings [R191, 2].</i>	

	Labour Act, 2003 (Act 651)	Maternity Protection Convention, 1952 (No. 103) and related Recommendation No. 95	Maternity Protection Convention, 2000 (No. 183) and related Recommendation No. 191	Convention on Workers with Family Responsibilities, 1981 (No. 156)
Source of funding of maternity leave cash benefits	Employer liability.	In no case shall the employer be individually liable for the cost of such benefits due to women employed by him [C103, 4 (8)]. The cash and medical benefits shall be provided either by means of compulsory social insurance or by means of public funds; in either case they shall be provided as a matter of right to all women who comply with the prescribed conditions [C103, 4 (4)]. Women who fail to qualify for benefits provided as a matter of right shall be entitled, subject to the means test required for social assistance, to adequate benefits out of social assistance funds [C103, 4 (5)].	Where a woman does not meet the conditions to qualify for cash benefits under national laws and regulations or in any other manner consistent with national practice, she shall be entitled to adequate benefits out of social assistance funds, subject to the means test required for such assistance [C183, 6 (6)]. In order to protect the situation of women in the labour market, benefits in respect of the [maternity] leave referred shall be provided through compulsory social insurance or public funds, or in a manner determined by national law and practice. An employer shall not be individually liable for the direct cost of any such monetary benefit to a woman employed by him or her without that employer's specific agreement except where: - such is provided for in national law or practice in a member State prior to the date of adoption of this Convention by the International Labour Conference [C183, 6 (8a)]; or - it is subsequently agreed at the national level by the government and the representative organizations of employers and workers [C183, 6 (8b)].	

Appendix I: Overview of Ghana Labour Act, 2003 (651) Maternity protection provisions and gaps (continued)

	Labour Act, 2003 (Act 651)	Maternity Protection Convention, 1952 (No. 103) and related Recommendation No. 95	Maternity Protection Convention, 2000 (No. 183) and related Recommendation No. 191	Convention on Workers with Family Responsibilities, 1981 (No. 156)
Health Protection	Unless with her consent, an employer shall not assign or employ a pregnant woman to do any night work or overtime [Article 55 (1)]. An employer shall not assign a pregnant woman worker to a post outside her place of residence after the completion of the fourth month of pregnancy, if the assignment, in the opinion of a medical practitioner or midwife, is detrimental to her health [Article 56 (1)].	See medical benefits. Night work and overtime work should be prohibited for pregnant and nursing women and their working hours should be planned so as to ensure adequate rest periods [R95, 5 (1)]. Employment of a woman on work prejudicial to her health or that of her child, as defined by the competent authority, should be prohibited during pregnancy and up to at least three months after confinement and longer if the woman is nursing her child [R95, 5 (2)]. Work falling under the provisions of subparagraph (2) should include, in particular— - any hard labour involving - (i) heavy weight-lifting, pulling or pushing; or (ii) undue and unaccustomed physical strain, including prolonged standing [R95, 5 (3a)]; - work requiring special equilibrium [R95, 5 (3b)]; and - work with vibrating machines [R95, 5 (3c)].	Each Member shall, after consulting the representative organizations of employers and workers, adopt appropriate measures to ensure that pregnant or breastfeeding women are not obliged to perform work which has been determined by the competent authority to be prejudicial to the health of the mother or the child, or where an assessment has established a significant risk to the mother's health or that of her child [C183, 3]. Members should take measures to ensure assessment of any workplace risks related to the safety and health of the pregnant or nursing woman and her child. The results of the assessment should be made available to the woman concerned [R191, 6 (1)]. In any of the situations referred to in Article 3 of the Convention or where a significant risk has been identified under subparagraph (1) above, measures should be taken to provide, on the basis of a medical certificate as appropriate, an alternative to such work in the form of - elimination of risk [R191, 6 (2a)]; - an adaptation of her conditions of work [R191, 6 (2b)];	

	Labour Act, 2003 (Act 651)	Maternity Protection Convention, 1952 (No. 103) and related Recommendation No. 95	Maternity Protection Convention, 2000 (No. 183) and related Recommendation No. 191	Convention on Workers with Family Responsibilities, 1981 (No. 156)
Health Protection		A woman ordinarily employed at work defined as prejudicial to health by the competent authority should be entitled without loss of wages to a transfer to another kind of work not harmful to her health [R95, 5 (4)]. Such a right of transfer should also be given for reasons of maternity in individual cases to any woman who presents a medical certificate stating that a change in the nature of her work is necessary in the interest of her health and that of her child [R95, 5 (5)].	- a transfer to another post, without loss of pay, when such an adaptation is not feasible [R191, 6 (2c)]; or - paid leave, in accordance with national laws, regulations or practice, when such a transfer is not feasible [R191, 6 (2d)]. Measures referred to in subparagraph (2) should in particular be taken in respect of: - arduous work involving the manual lifting, carrying, pushing or pulling of loads [R191, 6 (3a)]; - work involving exposure to biological, chemical or physical agents which represent a reproductive health hazard [R191, 6 (3b)]; - work requiring special equilibrium [R191, 6 (3c)]; - work involving physical strain due to prolonged periods of sitting or standing, to extreme temperatures, or to vibration [R191, 6 (3d)]. A pregnant or nursing woman should not be obliged to do night work if a medical certificate declares such work to be incompatible with her pregnancy or nursing [R191, 6 (4)]. The woman should retain the right to return to her job or an equivalent job as soon as it is safe for her to do so [R191, 6 (5)]. A woman should be allowed to leave her workplace, if necessary, after notifying her employer, for the purpose of undergoing medical examinations relating to her pregnancy [R191, 6 (6)].	

Appendix I: Overview of Ghana Labour Act, 2003 (651) Maternity protection provisions and gaps (continued)

Labour Act, 2003 (Act 651)	Maternity Protection Convention, 1952 (No. 103) and related Recommendation No. 95	Maternity Protection Convention, 2000 (No. 183) and related Recommendation No. 191	Convention on Workers with Family Responsibilities, 1981 (No. 156)
An employer shall not dismiss a woman worker because of her absence from work on maternity leave [Article 57 (8)]. A worker's employment is terminated unfairly if the only reason for the termination is due to the pregnancy of the worker or the absence of the worker from work during maternity leave [Article 63 (2e)].	While a woman is absent from work on maternity leave [...], it shall not be lawful for her employer to give her notice of dismissal during such absence, or to give her notice of dismissal at such a time that the notice would expire during such absence [C103, 6]. <i>Wherever possible the period before and after confinement during which the woman is protected from dismissal by the [...] should be extended to begin as from the date when the employer of the woman has been notified by medical certificate of her pregnancy and to continue until one month at least after the end of the period of maternity leave [R95, 4 (1)].</i>	It shall be unlawful for an employer to terminate the employment of a woman during her pregnancy or absence on leave referred to in Articles 4 or 5 or during a period following her return to work to be prescribed by national laws or regulations, except on grounds unrelated to the pregnancy or birth of the child and its consequences or nursing. The burden of proving that the reasons for dismissal are unrelated to pregnancy or childbirth and its consequences or nursing shall rest on the employer [C183, 8 (1)]. A woman is guaranteed the right to return to the same position or an equivalent position paid at the same rate at the end of her maternity leave [C183, 8 (2)]. Each Member shall adopt appropriate measures to ensure that maternity does not constitute a source of discrimination in employment, including - notwithstanding Article 2 (1) access to employment [C183, 9 (1)]. Measures referred to in the preceding paragraph shall include a prohibition from requiring a test for pregnancy or a certificate of such a test when a woman is applying for employment, except where required by national laws or regulations in respect of work that is: - prohibited or restricted for pregnant or nursing women under national laws or regulations [C183, 9 (2a)]; or - where there is a recognized or significant risk to the health of the woman and child [C183, 9 (2b)].	With a view to creating effective equality of opportunity and treatment for men and women workers, each Member shall make it an aim of national policy to enable persons with family responsibilities who are engaged or wish to engage in employment to exercise their right to do so without being subject to discrimination and, to the extent possible, without conflict between their employment and family responsibilities [C156, 3 (1)]. For the purposes of paragraph 1 of this Article, the term discrimination means discrimination in employment and occupation as defined by Articles 1 and 5 of the Discrimination (Employment and Occupation) Convention, 1958 [C156, 3 (2)]. Family responsibilities shall not, as such, constitute a valid reason for termination of employment [C156, 8].

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	Labour Act, 2003 (Act 651)	Maternity Protection Convention, 1952 (No. 103) and related Recommendation No. 95	Maternity Protection Convention, 2000 (No. 183) and related Recommendation No. 191	Convention on Workers with Family Responsibilities, 1981 (No. 156)
Entitlement to paid breastfeeding breaks	Yes. – Interruptions of work by a nursing mother for the purpose of nursing her baby shall be treated as working hours and paid for accordingly [Article 57 (7)]. Entitlement duration: 12 months [Article 57 (9b)].	If a woman is nursing her child she shall be entitled to interrupt her work for this purpose at a time or times to be prescribed by national laws or regulations [C103, 5 (1)]. Interruptions of work for the purpose of nursing are to be counted as working hours and remunerated accordingly in cases in which the matter is governed by or in accordance with laws and regulations [C103, 5 (2)].	A woman shall be provided with the right to one or more daily breaks or a daily reduction of hours of work to breastfeed her child [C183, 10 (1)]. The period during which nursing breaks or the reduction of daily hours of work are allowed, their number, the duration of nursing breaks and the procedures for the reduction of daily hours of work shall be determined by national law and practice. These breaks or the reduction of daily hours of work shall be counted as working time and remunerated accordingly [C183, 10 (1)].	
Number and duration of daily breast-feeding breaks	Number of daily breaks not specified; daily entitlement is 60 minutes [Article 57 (6)].	Number of daily breaks not specified in C103. <i>Wherever practicable nursing breaks should be extended to a total period of at least one-and-a-half hours during the working day</i> [R95, Article 3 (1)].	Number of daily breaks not specified in C183. <i>On production of a medical certificate or other appropriate certification as determined by national law and practice, the frequency and length of nursing breaks should be adapted to particular needs</i> [R191, 7].	
Breastfeeding and Childcare facilities	Not provided.	Provision should be made for the establishment of facilities for nursing or day care, preferably outside the undertakings where the women are working; wherever possible provision should be made for the financing or at least subsidising of such facilities at the expense of the community or by compulsory social insurance [R95, 3 (2)]. <i>The equipment and hygienic requirements of the facilities for nursing and day care and the number and qualifications of the staff of the latter should comply with adequate standards laid down by appropriate regulations, and they should be approved and supervised by the competent authority</i> [R95, 3 (3)].	Where practicable, provision should be made for the establishment of facilities for nursing under adequate hygienic conditions at or near the workplace [R191, 9].	All measures compatible with national conditions and possibilities shall be taken (b) to develop or promote community services, public or private, such as child-care and family services and facilities [C156, 5 (b)].

Appendix II: Characteristics of the informal economy

As in many other Sub-Saharan African countries, employment in Ghana is predominantly informal. It is estimated that more than 80 per cent of the employed are working in the informal economy,¹ with women being more highly represented than men (Danish Trade Union Council for International Development Cooperation, 2014; Osei-Boateng and Ampratwum, 2011; Osei-Boateng, 2011). Women in Ghana are generally less educated than men and informality is partly explained by low educational attainment (GSS, 2013b; Osei-Boateng, 2011). However, the reasons for women to set up their own business in the informal economy are manifold. Some are educated at university level, but are finding it difficult to find employment in the formal economy (Hampel-Milagrosa, 2011; Kabeer, 2012). Without adequate maternity protection, women with children are likely to stay in the informal economy to help them juggle breastfeeding, childcare and earning an income (Alfers, 2016; Cassirer and Addati, 2007).

Informal economy activities have become a key element of survival strategies adopted by many in Ghana, as in other economies, in response to declining welfare and wages (Kumi-Kyereme and Boachie-Mensah, 2012). Comparable also with other parts of Africa, is the heterogeneity and considerable variety of the urban informal economy which can mainly be categorised under services, construction and manufacturing. Street vending is also particularly prevalent in urban areas (ILO, 2013b; Osei-Boateng, 2011). In Africa, the majority of street vendors are women – 63 per cent in Kenya, 68 per cent in South Africa and 88 per cent in Ghana – compared to only 29 per cent in Buenos Aires (ILO, 2013b). In rural areas the informal economy is less diversified and mainly characterised by agricultural and agro-based processing activities as well as fishing and fish processing activities (Osei-Boateng and Ampratwum, 2011). Lack of skill and technology and the tendency to employ traditional and manual methods of production result in low productivity despite long shifts (Osei-Boateng and Ampratwum, 2011).

Although in theory applying to all sectors, labour regulations within the informal economy tend to be difficult to monitor and any protection and support is dependent on cultural norms and expectations. Kumi-Kyereme and Boachie-Mensah (2012: 5) summarize the characteristics of the informal economy as follows (see also Akorsu, 2013; Musiolek, 2002; Osei-Boateng and Ampratwum, 2011; Tesselaar, 1998):

Informality can include all varieties of absence of protection, circumvention of laws and levels of labour insecurity. Particularly, informality appears as absence of labour contracts and collective bargaining agreements, extreme wage flexibility, seasonal or hired employment, child labour, leave not granted according to the law or refused arbitrarily, excessive hours, unpaid or improperly paid overtime, wages below a living scale, etc.

¹ “The informal economy consists of a host of activities which are unregulated”.

Furthermore, decent work deficits in the informal economy in Ghana include poor occupational health and safety standards, lack of job security and social protection, including paid sick and maternity leave (as discussed in Section 3). The overall lack of labour standards application in the informal economy of Ghana is due to factors such as ineffective enforcement, the *ad hoc* nature of work organisation. In addition, trade union representation is very low although there are other forms of representation such as associations that represent the interests of self-employed in particular in sectors as e.g. trading. Informal economy employers and self-employed workers are also either ignorant about safety and protection issues, or argue that they simply cannot afford better working conditions (Akorsu, 2013; Osei-Boateng and Ampratwum, 2011).

A common feature of work arrangements in the informal economy is that there is a joint understanding between employer and employee about the nature of these conditions. Most employees and apprentices in the informal economy do not have contracts or written agreements (Osei-Boateng, 2011). On the part of the employees, the acceptance of the conditions is both voluntary and forced as they are able to find employment which they might not have been able to find in the formal economy, although they are not covered by basic social protection (Kumi-Kyereme and Boachie-Mensah, 2012; Musiolek, 2002). This relationship therefore also involves a high economic and personal dependency on the employer and results in the employee having a very low sense of entitlement (see Section 2). According to Osei-Boateng, 2011, few employers provide even basic medical care to cover illness such as common headache, malaria or fever and workers risk losing their jobs if they suffer prolonged illness or become pregnant. However, employers, employees or apprentices are often related in some way through, for example, marriage, another relative, friend or acquaintance (Baah-Nuakoh, 2003; Kumi-Kyereme and Boachie-Mensah, 2012). Recruitment is carried out informally through friends and family, and verbal agreements are reached with respect to the conditions of the arrangement (Osei-Boateng, 2011).

Another important group of informal economy workers are domestic workers, who are also more often female than male (Osei-Boateng, 2011). They tend to come from poorer households and work, for example, as nannies, house helps, cleaners, or cooks workers. Although, according to official statistics (GSS, 2013b), they are said to constitute only a small percentage (0.2%) of the employed in Ghana, in reality the number can be expected to be much higher. It is accepted practice among many ethnic groups in Ghana to give their children to families (comparable to foster parents) of better socio-economic standing, and who have a good reputation in the community (Clark, 2002). In these families, the 'foster-children' are usually considered kin rather than domestic workers, although they are expected to perform household chores, sometimes to the detriment of their education (Osei-Boateng, 2011). Such domestic workers play a crucial role in supporting working mothers.

There also is a strong gender dimension to such types of work with women frequently being paid less (sometimes only half) of male rates for a day's work as their work is considered as 'less arduous' (Kabeer, 2012; Whitehead, 2009). There is considerable evidence that economic activity within the sphere of family relations, in particular unpaid work in farm and family enterprises, is characterised by the weakest transformative potential for women's livelihoods (Kabeer, 2012). In her study of women's economic empowerment, Kabeer (2012) found that a positive impact of informal work was more likely to occur in off-farm self-employment, which gave them some control over their incomes and brought them into the public sphere, rather than informal waged or farm-based work.

In any case, informal economy work leaves the poorest workers in the economy in a very vulnerable position, as they tend not to be covered by social protection and to have very limited opportunities for upward social mobility. These poorest groups are trapped in poverty, as they earn too little to pull themselves out of it (Kumi-Kyereme and Boachie-Mensah, 2012; Osei-Boateng and Ampratwum, 2011). In order to address the issue of deeply entrenched poverty of workers in the informal economy, Ghana has introduced a series of social protection initiatives which target the most vulnerable workers (as discussed in Section 3.2).

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