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'His Job is Already Done': Excluding and Excusing Men from Responsibility for Child Health

The title of this paper emerged from an interview that I undertook with an Australian woman who I will call Emma. Emma is aged in her late twenties and she has two sons, one of whom was born with a severe health problem that affects his heart. Throughout the interview Emma discussed her beliefs about the cause of her son's health problem and, in doing so, expressed a strong belief that men lack influence in creating healthy pregnancies and in promoting child health. For Emma, men's role is limited in that "once the sperm's got in, that's it; his job's sort of finished." Emma was not alone in this belief. It permeated the narratives of many of the mothers I interviewed for this study. A similar assumption also dominated the medical literature and other health information that I analysed, which was focused on explaining the causes and prevention of child health problems.

Throughout this paper I examine selected findings from research that I have undertaken during my PhD. In doing so I explore how the perceived lack of male influence on child health is constructed and reinforced in contemporary Australian society. In particular I focus on examining the potential influence of medical and public health discourses in contributing to a normative absence of men within understandings about the origins of child health. As part of the analysis that I present in this paper, I highlight the broader social implications of discourses which operate to excuse and exclude men from understandings about pregnancy and child health. In particular, I argue that the exclusion of men from discourses around reproductive health presents a barrier to egalitarianism and contributes to the social conditions in which women become entangled in relationships of individual responsibility for determining the health outcomes of their (future) children. To begin developing these ideas I provide a brief review of relevant literature.

Strong Sperm and Absent Men

The ideas that men lack influence in contributing to the health of a pregnancy and in contributing to the health of their child have an historical basis. As explained by Martin (1989:27) it is useful to reflect on ideas from the past, particularly ideas that now seem primitive or 'wrong', to understand how cultural and gendered assumptions shape contemporary understandings about scientific phenomena. According to work by Daniels (2001), debates over the origins of foetal harm have been consistently based upon understandings of male virility and female vulnerability. In an important paradox, historical understandings of male virility render sperm either completely *invulnerable* to harm from the toxicity of particular agents and environmental exposures or, conversely, to be rendered completely infertile if they do become damaged (Daniels, 2001:313-314). Despite such a paradox it is clear that these ideas reflect enduring stereotypical assumptions about the strength of the male body and its self-containment. In addition, the belief that damaged or 'tainted' sperm will be rendered completely *infertile* conveys the idea that any sperm which successfully fertilises an egg is necessarily 'normal' (Daniels, 2001:317). This equates an ability to penetrate an egg with a measure of normality, meaning that sperm which succeed in achieving conception are assumed to be strong, undamaged and, therefore, healthy.

Further contributing to these ideas are early understandings about sperm as the seed of life. According to early theories of reproduction, which were not challenged scientifically until the turn of the twentieth century, men were seen to provide the 'seed', or entire genetics, for reproduction whereas women provided only the incubator, or womb, in which that seed grew (Stonehouse, 1994:1; Delaney, 1988:85; Tuana, 1988:38-39). Following from this division, the womb of a woman was regarded as the medium responsible for supporting life and for influencing *how* a child grew, similar to the nurturing role of soil (Delaney, 1988:62; Fausto-Sterling, 1987). This idea interacted with those surrounding the normality and positive (life-generating) power of sperm to explain problems with the health of a child as necessarily the result of a defective, and possibly, immoral female body. Stemming from this, problems such as 'barrenness' (an inability to conceive) or the birth of a child with health problems were all blamed on women (Stonehouse, 1994:60). The 'soil' was also blamed if conception could not occur, as if it was regarded too acidic or too barren to support life (Stonehouse, 1994:61). Such ideas had the effect of naturalising women's responsibility while establishing the legitimisation of men's exclusion from understandings about child health problems.

Perpetuating the dominant focus on women and the corresponding absence of a focus on men's influence, I have identified an enduring discourse in other bodies of literature which represent men and fathers as occupying a peripheral role in regard to reproduction. An example of this is provided by philosophical analyses of men's encounters with the pregnant body which indicate that men can feel uninvolved in pregnancy because they experience a sense of biological distance from it and, therefore, it becomes a disembodied experience for them (Dempsey, 2004; McCreight, 2004). A similar discourse is also evident in

FURTHER INFORMATION

ABOUT THE AUTHOR

Toni Delany's PhD thesis explored the role of medical and public health discourse in influencing constructions of maternal responsibility for child health. Through her research Toni is interested in exploring the relationships between the biological and the social and, specifically, how understandings about health become influenced by, and reinforcing of, existing social arrangements.

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some public health related literature, especially in the work of David Gordon (1995), who asserts that men's sense of masculine identity may suffer more from a loss of sexual function than from becoming infertile. This has clear links to dominant understandings of hegemonic masculinity which distance men from the nurturance, and reproduction, of their children (Gordon, 1995:250).

The current lack of focus on men may also be related, in part, to gendered differences in political movements. The health needs of women were a focus in the women's movements that emerged in the 1960s and 1970s. The current dominance of a focus on women's health in Australian society (although this is still often threatened by political and financial factors) is testament to the success of these movements in bringing the health needs of women into popular consciousness (Manderson, 1998). Much of the research in the field of women's health is still premised on the belief that men occupy a more privileged position in society. This, therefore, makes a specific focus on men's health unnecessary and potentially threatening to the focus and resources directed to women's health. This may, in part, have contributed to the current lack of research focus on how it is that men's biology or behaviours influence their reproductive health and the subsequent health of their children.

I argue that a more *relational* focus in studies of reproductive and child health can be beneficial to provide greater understanding of what influences the health of pregnant women and the children they give birth to. In the context of this paper, I use the term 'relational' to highlight the potential influence of the relationship between the two members in a heterosexual relationship on the health of the child they conceive and, in many cases, also continue to raise. I argue that a greater focus on relationality is required in order to adequately understand the factors that contribute to the contexts in which women's pregnancies are undertaken and in which the origins of child health outcomes are interpreted. Greater recognition of this relational context of reproductive and child health is vital because men have both a biological and a social impact on the children they produce, not only through their biological contribution of sperm but also in terms of their role in sharing and shaping the environment in which a pregnancy proceeds and in which a child is raised. Therefore recognition of this role is important especially because, as Rob White claims, "men's health is a social issue, with implications for all sections of society" (White, 2002:268). Furthermore, recognising men's influence and participation is vital as part of efforts to weaken current barriers to more egalitarian parenting relationships, which can offer benefits to women, men and children.

To further establish the context for the arguments that I present in this paper I suggest that the propositions that men can, and should, occupy greater focus in relation to reproductive health and child rearing stem from the ideals of mutuality which characterise intimate relationships in contemporary neo-liberal society. Such ideals provide the basis for expectations surrounding, and beliefs about the possibility of, men's greater involvement in pregnancy and reproduction. The recency of men's inclusion in these social domains is based on the belief that changes in social models of gender have freed men from the constraints of dominant masculinity which discouraged them from nurturing. Therefore, in contemporary society there is often an expectation that egalitarianism will be present during a pregnancy, and, as such, many post-modern couples tend to have strong desires to create egalitarian relationships (Swanson, 2004:2). However, according to Margaret Swanson (2004) couples experience difficulties in achieving such equality. Such difficulty emerges because, as my research reflects, the structure of society and of gender roles has, in practice, not yet changed enough to accommodate egalitarian roles for men and women (Swanson, 2004:2). My research suggests that discourses around reproduction and child health contribute to the difficulties in achieving egalitarianism, specifically by reinforcing a normative absence of men within understandings about the origins of child health. I explain how this reinforcement occurs, and some of the effects it produces, through my analysis of selected research findings.

Methods

This research involved a series of semi-structured, in-depth interviews with women who mother children with health problems, interviews with medical professionals, and analysis of texts. I also analysed 10 chapters from medical textbooks which are used as recommended texts in undergraduate and postgraduate medical education in Australia. These chapters were focussed on explaining the development and origins of child health problems. In addition, I analysed 15 medical journal articles selected by searching the international medical database PubMed for the subject headings obstetrics and perinatology (which is the field of study relating to the management of high risk pregnancies or pregnancies affected by complications) limited to those with a high impact factor of two or over published throughout 2000 to 2007. Articles that discussed the causes or preventability of the child health problems that I selected as case studies for the interviewing component of the research.

I also analysed 22 health education resources, such as pamphlets, that are routinely distributed at the first antenatal appointment in South Australia (SA). These resources are intended to explain how healthy pregnancies can be achieved and how specific child health problems can be prevented during pregnancy. I chose to contain my analysis of health education resources to SA only since that is where I am located and I wanted to collect the resources in person so that I could speak with midwives and obstetricians about how specific resources were used during antenatal appointments. In addition, during the interviews I asked women from other states what resources they were given and the information contained in these appeared similar to what I collected from SA.

Interviews

The mothers I interviewed were aged between 26 and 42. All of these women were mothers of children aged six years and younger who were affected by one of the following health problems:

- congenital heart disease (CHD). CHD is a term used to refer to a variety of different problems that can develop in the heart of an infant before birth.
- naevus, which involves the formation of pigmented (dark coloured) growths on the skin before birth.

- spina bifida, which occurs when the spine does not form completely. The impaired spinal development can cause problems with mobility and continence.

These three particular health problems were chosen because they have different characteristics which may influence the experiences of mothers. The selection of specific health problems was also practical because it allowed me to work with relevant support groups to invite women to participate in the interviews. Interviewing women who already had access to established networks of support or information through their groups was valuable because some of the issues that we discussed during the interviews were sensitive and emotional.

While I undertook the majority of the interviews in person, I also interviewed some women by telephone because they lived outside of SA. The study included women from Queensland, New South Wales, Victoria and SA (both metropolitan and rural locations). During the interviews, I asked some broad questions but, for the most part, the women shared their experiences in an unrestricted way by raising issues that were relevant to them.

I interviewed all of the medical professionals in person at their place of work. I undertook interviews with seven medical professionals who work in the fields of obstetrics, paediatrics, neonatology and genetics. The group of medical professionals consisted of two females and five males. During these interviews we discussed the participants' experiences of consulting with couples as well as their own opinions about the origins of child health problems. Following each of the semi-structured, in-depth interviews I transcribed the discussions. This facilitated my early analysis of the data, which I continued during a subsequent stage of critical discourse analysis (Fairclough, 1989, 1995).

In addition to the interviews with the mothers of children with health problems, I initially considered interviewing men who father children with congenital health problems. However, I decided not to pursue these interviews. The main reason for this was related to the time constraints imposed on my fieldwork. Given the specific focus of the research I needed to give priority to exploring the contrasts and similarities between women's views, the views of medical professionals and the content of the medical literature and health education resources. However, I acknowledge that by not capturing the experiences of men who father children with health problems I have some role in reinforcing the dominant focus on mothers in understandings about child health. Given this, and the potential gains from exploring the insights of men, I suggest that further research be undertaken to build upon the findings of this study and to explore further the micro-dynamics that contribute to the normative absence of men from the context of reproductive health.

Analysis processes

Critical discourse analysis involves reading interview transcripts with a view to exploring the underlying discourses, or very simply, the ways that people talk, think, act and interact in relation to particular issues (Wetherell, Taylor & Yates, 2001). Within a critical approach, discourses are believed to be structured in ways that support some individuals and groups while oppressing others (Holstein & Gubrium, 2005). In this sense, discourses reproduce power relations while also operating to define shared beliefs "which give structure to everyday life and which assist individuals to make sense of their world" (Lupton, 1994:29). By the very nature in which discourses operate they usually remain implicit. This means that rendering particular discourses visible is one of the central tasks of critical discourse analysis (Bacchi, 1999; Lupton, 1994). While undertaking the discourse analysis of the interview data I was concerned with exploring the issues and concepts raised explicitly by the participants and also the implicit meanings that permeated the narratives. Applying such a focus assisted me to explore what factors influence the participant's beliefs and also to explore what social implications may arise from the issues and experiences they discussed.

To analyse the medical articles, textbook chapters and health education resources I undertook an initial content analysis followed by a secondary, more in-depth, stage of critical discourse analysis. The application of content analysis techniques during the first stage of the analysis process was useful for two main reasons. First, the content analysis facilitated my early immersion in the data because it encouraged me to read the literature closely. Second, the results of the content analysis informed the approach that I applied during the subsequent critical discourse analysis.

I began the content analysis by reading each of the selected articles, textbook chapters and the health education resources. I then re-read each of the sources and made notes about the topics and issues that were discussed. Throughout the content analysis of all of the texts I compiled tables that included the quantified results of the analysis. Following the content analysis I began the process of critically analysing the discourses that permeated the sources.

During the discourse analysis I devoted further attention to the presences and absences that I identified during the content analysis but I also examined the sources to consider the implied values and concepts that emerged from them rather than only those specifically mentioned (Fairclough, 1989, 1995; Wetherell, Taylor & Yates, 2001). The aim of this was to develop a more comprehensive understanding about the implicit meanings that arise from medical and public health discourses surrounding pregnancy and the discussion of child health problems.

Men's Virility and Women's Pregnancies

One of the main findings is that throughout all of the data sources responsibility for reproductive health outcomes was directed mainly at women before and during pregnancy and because of this, a perceived lack of male influence was inferred. One way this occurred is through women's positioning as the only people associated with reproductive health. This positioning occurred implicitly since my research indicated that men are largely excluded from information and practice around reproductive health.

Discourses of male exclusion emerged particularly strongly from my analysis of the health education

materials that are routinely given to couples at their first appointment with a midwife or obstetrician. There are currently no health education materials that are routinely offered to men about reproductive health or pregnancy in SA. Instead all routine information is provided to women. There are some pamphlets that can be offered to male smokers at the discretion of health care providers, however, this is not standard routine across Australia or in South Australia. Furthermore, the content of these pamphlets do not link men's smoking with the health of their sperm or the health of their future children. Instead the content encourages men to quit smoking so that this will act as an incentive for their female partners to also quit and, therefore, reduce the effects of maternal smoking on the growing foetus.

The relative exclusion of men from health information and practice around reproduction also became particularly evident during the interviews that I undertook with mothers. I asked all the women if their partner was provided with advice about how he could promote the health of their baby before or during pregnancy and most said no. Information was instead directed mainly at the female member of the couple. For example, Jenny said:

> My husband came as well to a lot of the appointments, I think the advice really was targeted at the female ... I can't remember anything being targeted at him. Oh, they did say some things like if you're trying to conceive the male should try and cut down alcohol and things like that, but they didn't say stop, they said cut down, whereas for the female, it's like no—forget it! Forget it for the whole nine months after too actually. (Jenny, 30 years old, 5 month old son with spina bifida)

As inferred by Jenny when women did recall their partners being provided with limited advice, this was consistently related to ways that the man could ensure his fertility rather than promote the health of his partner or child. This is highlighted here by Kate in response to me asking whether her partner received any reproductive health advice:

> Kate: Nothing. He would've got nothing. Oh no hang on ... undies [laughs]. I remember something to do with the undies or the boxers you know, that thing, that was the only thing I've ever heard to do with yeah the whole pregnancy thing.
>
> Toni: So do you think that he was expected to be involved in helping you to keep yourself healthy during pregnancy?
>
> Kate: No. No. I don't think so. And I felt like it was just my job sort of thing and I guess he just felt the same.
>
> Toni: Why did you think that?
>
> Kate: Um ... just because it's me ... I don't know ... me looking after the little thing I guess. (Kate, 35 years old, 5 year old son with congenital heart disease)

The last quote highlights another important related theme. The relative exclusion and absence of men from the context of reproductive health may have the effect of reinforcing women's responsibility for reproductive outcomes. This is particularly important when these outcomes are less than desirable because it may cause women to be blamed or to blame themselves.

My analysis reveals that one reason that men are largely excluded from mainstream advice is that in relation to reproductive health sperm is still represented as a 'safe' substance which cannot be damaged by men's behaviours or what they are exposed to. This differs from the way that female eggs are understood as being quite vulnerable to damage. Such an assumption about sperm was expressed by Maureen who is a genetic counsellor:

> Toni: We've talked about women expressing feelings of responsibility or guilt, do you find that similarly with men?
>
> Maureen: I probably haven't had anywhere near the number of conversations with men. And I mean there's virtually nothing that can affect sperm ... we don't know of anything really that affects sperm that can then affect a conception. So I don't think that men do feel at all the same level of ... uh and they're not the ones that have carried a pregnancy so I don't think it is anywhere near the same issue for men as it is for women.

The presumed 'safety' of sperm was also reinforced in one of the medical textbooks where the authors implied that the origins of childhood health and illness develop only after conception. This inference is highlighted by the quote:

> The task of paediatricians is not limited to childhood. It is increasingly to promote health and prevent disease from the moment of conception forward. (McMillan et al., 2006:174)

However, medical evidence exists to indicate that the presumed safety of sperm is not necessarily accurate. Sperm are not impervious to damage which can be transmitted to their offspring. In support of this argument I note recent medical evidence of the associations between sperm damage and air pollution (Rubes et al., 2009) and occupational exposures (Hsu et al., 2006).

Excluded Fathers and Responsible Mothers

Men's generalised exclusion from the reproductive health context establishes the potential for men's legitimate exclusion from parenting and from responsibility for child health. From my interviews it appears that even when couples attempt to resist dominant discourse and demonstrate agency by attempting to

engage in more egalitarian relationships around reproductive and child health, the discursive absence of men from their child's healthcare remains powerful. This idea is supported by the following quote from Abby:

> Even when we try to share the responsibility it's hard to do so. Like one time I was really tired and we had to take Harry into the emergency room at the hospital to get checked. And like I just didn't want to deal with it. Anyway so my husband talked to the nurses and stuff and I stayed behind him. But then I found them looking around my husband at me! Talking to me, like I should be the one dealing with it and not him. All the time it's like it's my responsibility and not his.
> (Abby, 30 years old, 5 year old son with congenital heart disease)

This quote and my broader analysis also suggests that excluding and excusing men from the context of reproductive health is an important process through which women become centralised as those most appropriately responsible for ensuring the health of their children before, during and after pregnancy. This perpetuates damaging stereotypes that reinforce the gendered division of care for children and which render almost inescapable the traditional gendered division of parenting tasks.

Individual Women and a Lack of Relationality

My analysis of medical literature and health education materials also suggests that individual women, and, again, not individual men, are consistently represented as having considerable control over their reproductive health regardless of their social circumstances. In these texts there are many different messages about things women should do to achieve healthy reproduction. On the surface it looks as though these messages do reflect consideration of broader factors. For example, the advice for pregnant women to avoid soft cheeses appears to acknowledge the potential for some foods, which are part of the external environment, to influence a pregnancy. However, it is my argument that the actual amount of consideration that is provided to broader social, environmental, and relational influences is limited at best.

I argue that mainstream discourse currently contains thinking to the female body - and particularly what goes into it - while largely ignoring the range of potential broader influences. In particular, the potential influence of shared behaviours between men and women is not considered within mainstream discourse about reproductive health. This is even though these behaviours and the dynamics of heterosexual relationships may have an influence. For example, dynamics relating to the distribution of finances, shared eating practices and domestic violence may all have an impact on the health of a pregnancy, the woman carrying a pregnancy and, therefore, also on the health of the child who will be born.

The generalised omission of considerations about the relational context of reproduction, and the corresponding dominance of understandings about the power of the individual, leads to the construction of reproductive health as something that can be chosen by women through their behaviours and decisions. Furthermore, the availability of an abundance of health advice renders healthy outcomes as available to all women providing that they make the 'correct' choices. Importantly, these are 'choices' which are represented as being unmediated by social context. Within such a discourse the potential for individualised blame is considerable because less than desirable outcomes may be interpreted as a woman's individualised failure.

These kinds of understandings were expressed frequently during the interviews. For many of the women claims of complete free choice provided a basis for their understandings about child health and they actively replicated these ideas. For example reflecting back on her pregnancy Karen said:

> Karen: Well ... I think that all the 9 months that you carry a baby you are in total control and ... you're the one person who does have control over your baby's life. I think women are ... they have that responsibility.
>
> Toni: Do men also have that responsibility?
>
> Karen: Oh no. Men can be supportive [laughs] but I think ultimately it's the woman who can not only make these decisions but execute them as well.
> (Karen, 35 years old, 2 year old son with congenital heart disease)

The opinions of several medical professionals also support understandings of reproductive health as something that can be chosen- or not chosen- by individual women. Bill, an obstetrician, inferred this when he said:

> Women do feel responsible [for their child's health problems]; they do feel guilt, um ... because they are responsible. I mean they created this child. But uh ... whether it's perfect or imperfect, if you want to consider a handicap as imperfect, a lot of people wouldn't. Um ... and so some might have a pathological feeling [of guilt] to that matter which then would need to be handled. But uh ... but I think that extends to other things in life too. If you have a car accident you wish you were driving 5 kilometres per hour slower, or weren't driving at all or you walked, that's life ... people make choices and sometimes you have to live by the outcome.

This quote highlights that some of the strongest, and perhaps most implicit, dynamics through which maternal responsibility for child health becomes constructed and legitimised within medical and public health discourses arise from the dominance of ideas based on ideologies of neo-liberalism and individualism. In the social milieu these ideologies, of course, interact with traditional structures of gender inequality to create even greater burdens for women. In a social context that is permeated by ideologies of neo-liberalism and individualism, and supported by existing social inequalities, it is difficult to direct attention to the relational, social and environmental conditions that can make some behaviours and some health outcomes either possible or difficult for individuals. In this context, as a society, we employ a cultural repertoire, which is

perpetuated and reinforced through medical and public health discourses, to explain the realities of individuals as based mainly upon their choices, moral character, will power and sense of responsibility (Kukla, 2008:83; Tierney, 2004). This individualistic cultural repertoire isolates individuals from the broader context in which they exist and represents them as self-defining agents who can act outside the influence of contextual forces. Such individualistic logic encourages health information and practice that has a predominant focus on the choices and behaviours of women rather than on creating social and environmental conditions that are conducive to healthy outcomes for women, men, children and families. Despite this conflicting situation, not making the 'right' choice to 'protect' the interests of the (future) child is regarded as a personal failure on behalf of a woman. This results in women continuing to experience a mismatch between the expectations imposed on them as reproductive beings, the social ideals of egalitarianism and their lived experiences of pregnancy and mothering (Roe & Morris, 2004:14).

Furthermore, the dominance of an idealised notion of 'free choice' within the ideologies that permeate medical and public health discourses encourages a redistribution of risk away from structural and institutional factors to the individual. This redirects focus from systems of inequality and social determinants and concentrates it on individual behaviour within the context of a risk society. However, my research, as well as other feminist research (Forbes, 2008), indicates that women's choices are structured and contained. Despite such feminist critique, choice and the 'right to choose' are still located predominately within discourses of individual empowerment in relative isolation of consideration about the social and political structures in which they are embedded (Lippman, 1999; Sherwin, 1998). Relying on explanations based on understandings of individuals' free choice and personal agency obscures the processes through which choices become structured and made available or denied. In particular, understandings of 'choice' as a gender neutral concept obscure the power relations that serve to make particular choices available to women while also reaffirming existing systems of social privilege and concealing the many differences between women that enable or disable their ability to choose (Lippman, 1999:282). In addition, adequate access to particular social resources is essential to allow women adequate choice and, even when these resources are present, choice always remains bounded by social forces, particular those that operate through public health and medicine, in a way that means choice is never completely 'free' (Petchesky, 1993). Consistent with these ideas is the work of John Comaroff and Jane Edwards who explain that in the absence of a conceptual framework which extends beyond the individual, guilt and blame is deflected "from an externalized to an internalized moral discourse" (Comaroff, 1982:56). "Illness is thus experienced as a private trouble" (Edwards, 1994:2) that, I argue, can then be explained in terms of women's failure, particularly in a context where men are both discouraged from actively participating in and from taking responsibility for the creation of healthy pregnancies and children.

Conclusion

Throughout this paper I have argued that medical and public health discourse has a role in constructing and reinforcing the perceived lack of male influence on pregnancy and child health. I have also made clear that the exclusion and excusing of men operates in conjunction with the absence of detailed consideration about the relational and social influences on reproductive health to encourage and legitimate the attribution of responsibility for child health to women. The individualisation of responsibility provides the potential for women to experience guilt and blame for the health problems of their children given that both reproductive and child health are constructed as things that are controllable and achievable through selecting 'correct' behaviours.

The discourses that I have highlighted also reinforce and perpetuate gendered stereotypes by positioning women as most closely linked to their children's health when factors outside of the maternal body may have an influence. Men become excused from reproductive responsibility on the basis of their presumed non-influence as well as through the positioning of women as more legitimate targets for medical and public health intervention. This finding is particularly important because the exclusion of men early in their experiences of becoming a parent is likely to have ongoing effects for how we as a society understand the role of fathers. It may also influence the quality of fathers' relationships with their children. To alleviate current pressures on women, and to weaken the strong, resistant barriers to greater egalitarianism, I argue that a more relational focus is necessary when we consider the origins of child health and who or what influences these origins.

In closing, it is important to acknowledge that the findings that I have explored in this paper emerge from the operation of normative heterosexuality as it is played out in the contemporary neo-liberal social context. Acknowledging the heterosexual focus in this paper is vital since relationships to reproduction not only involve gender but they also operate in a matrix of relationships based on sexuality. Therefore, it cannot be assumed that the issues that are raised in this paper apply to families in which the dominant modes of heterosexuality do not exist. This warrants further investigation to explore how constructions of gender impact on responsibility for child health within families where non-hegemonic relations of masculinity, femininity and heterosexuality operate.

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