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**"THINKING TOO MUCH" AND "WORRYING TOO MUCH":
GHANAIAAN WOMEN'S ACCOUNTS OF THEIR HEALTH PROBLEMS**

By

JOYCE YAA AVOTRI, B.A., M.A.

A Dissertation

Submitted to the School of Graduate Studies

in Partial Fulfilment of the Requirements

for the Degree

Doctor of Philosophy

McMaster University

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DOCTOR OF PHILOSOPHY (1997)

McMaster University

(Sociology)

Hamilton, Ontario

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Ghanaian Women's Accounts of their Health Problems

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ABSTRACT

Women's voices are usually absent in the literature on women's health in developing countries. We know little about women's own concerns about their health, the ways in which they understand the problems they experience, how they cope and what changes they think would help to improve their health. The information on women in developing countries is typically provided by academics, health professionals, non-governmental organizations and policy makers. We do not know whether this captures the views of women themselves. Moreover, explanations of women's health often rely on biomedical and cultural/behavioural models and we do not know whether these reflect women's own approaches to understanding their health.

The research reported here documents the health problems and concerns of Ghanaian women. Using the concept of the social production of illness, the research also aimed to determine whether women traced their health problems to the social and material conditions under which they lived. The data are drawn from semi-structured interviews with 75 women in Kpando, a community in south-eastern Ghana. The data show that, when asked to talk about their health, women do not dwell on reproductive health issues. Rather, they emphasize "worrying too much" and "thinking too much", as well as a range of physical health problems. In their explanations of health problems women talked about their roles in social reproduction and production and about the links between their social relationships and their health. In order to perform their roles and avoid disrupting household organization, women

relied on short term coping mechanisms, especially painkillers. In the longer term they called for an improvement in the situation of women through social structural changes - better access to education, jobs and credit. The research findings prompt questions about commonly held assumptions about women in the developing world and they illustrate the value of listening to the voice of women.

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CHAPTER 1: INTRODUCTION

Since the Decade for Women was launched by the United Nations in 1975 interest in women and development has grown substantially. One aspect of women's lives that has received increased academic and policy attention is women's health. The Primary Health Care (PHC) programs initiated after the declaration of "Health for All by the Year 2000" at Alma-Ata in 1978 emphasized the importance of women's health. As a result, in the 1980s a variety of PHC initiatives were specifically undertaken to improve women's health. Most of these efforts focused on women's reproductive health creating the impression that maternal health problems were the only, or at least the most important, health problems women faced.

After several years of PHC initiatives, researchers and policy makers have started to assess what they have learned so far and to raise questions about what else can be done to improve women's health in developing countries. Scholars interested in women's health are starting to realize that aspects of women's health status other than reproductive health require attention. The importance of a broader understanding of the determinants of women's health status is being increasingly stressed, especially as structural changes in many developing societies are exposing women to new situations which are hazardous to their health. The biomedical model is being questioned and the importance of social determinants

of women's health is being acknowledged. This dissertation follows in this new direction being charted in women's health. It examines women's health problems in the developing world in terms of the social production of health and illness.

This study documents women's health problems and aims to understand the links between women's health problems and the nature of women's lives. The research seeks to articulate the views of women themselves by enabling women to talk about their health problems and concerns. Traditionally, academics, health professionals, non-governmental organizations and policy makers have dominated discussions of women's health. The voices of women themselves have rarely been heard. We know very little about women's own concerns, how they understand the health problems they experience, what they feel influences their health, how they cope and what they think would improve their health status. This type of research is relatively new in developed countries and is even less common in developing countries.

In order to explore my questions about women's health, I conducted research among women in a Ghanaian community over a period of five months. This thesis reports on women's accounts and shows how their health was linked with their roles in biological and social reproduction and productive activities, and how it was also influenced by social relationships. The interviews illustrate that women viewed health in a holistic manner. In their explanations of the causes of health problems women rarely relied on the biomedical or cultural-behavioural perspectives which tend to focus on biological causes or individual

blame. The women I interviewed saw their health in the context of the social and material conditions of their lives. To them, health cannot be considered outside or separate from daily life.

The study is divided into nine chapters. In Chapter Two I review the general literature on women's health, providing a context for this study by highlighting certain key problems in the existing literature. I also explore the theories that academics and policy makers use to understand women's health status. I start by looking at the ways in which women's health in developing countries has mainly been constructed in biological reproductive terms. Insofar as other aspects of women's health have been studied, the focus tends to be on physical illnesses. Because women's health in developing countries has been explained mainly in biological and cultural-behavioural terms, the result has been a partial explanation of why women fall ill. I argue that the social production of illness perspective is broader and more useful in terms of understanding women's health.

In Chapter Three, I situate the research in the Ghanaian social context and present a general picture of the life of Ghanaian women. I examine the social structures which impinge on women's lives and discuss sociocultural perceptions and images of Ghanaian women. The chapter considers women's roles and responsibilities in the household and their income-generating activities both at home and outside the home. I also outline the barriers that women encounter as they go about their productive activities. I further examine the

impact of the Structural Adjustment Program on women's lives. The chapter ends with a sketch of the general health situation of Ghanaian women.

The research was conducted in Kpando, Ghana, West Africa and in Chapter Four I describe my methodology and field experience. The data are qualitative; the aim was to allow women themselves to talk about their health problems and worries. In-depth interviews were conducted in the local language and Chapters Five, Six, Seven and Eight present the results of the research. Chapter Five focuses on women's own accounts of the types of health problems they experienced or worried about. The health problems they mentioned were quite different from those emphasized in the literature on women's health in developing countries.

Women understood their health in broad terms, relating it to the social and material conditions of their day-to-day lives. In Chapter Six I show how women linked their health to both their work and their poor financial situations. Women explained that their heavy work loads and multiple work activities made them ill. Even where they engaged in significant productive activity, they did not make enough money to maintain their households and this added stress to their already difficult lives.

Chapter Seven continues the discussion of how women understood their health and documents the links women made between their health and their relationships with their partners, children and other members of their families. The women said their relationships, especially those with their male partners, were sometimes characterized by conflict and this negatively affected their well-being. The discussion points to the ambivalent nature of

women's relationship with men and argues that although men are very important in women's lives, they are at the same time a source of conflict and stress for women.

Women's coping mechanisms and their suggestions for change are the focus of Chapter Eight. I examine the various ways in which women said they coped with their problems on a day-to-day basis. Medication, especially the use of painkillers, is one method by which women coped. The women said their roles were indispensable to the smooth running of their households and since they could not afford to disrupt the household organization, they relied on painkillers so that they could continue to work. Other sources of coping for women were alcohol, religion and social support from relatives and friends. The chapter further looks at the suggestions women made to bring about a more enduring improvement in their lives and health. While some women suggested better medical care facilities, many of them suggested better education and jobs and emphasized the need for income-generating activities and access to credit and other resources.

Chapter Nine is the conclusion of the study and it ties together the arguments of the thesis. In this chapter I summarize my research findings. I reflect on what my findings can contribute to questions of theory, methodology and substantive issues on women and their health. I also discuss the implications of my findings for future research and policy making, particularly in relation to women in developing countries. This chapter further shows how new insights from my study reveal flaws in the assumption that policy makers and specialists on women are the most qualified to talk about women's concerns. I point out some ways in

which we could correct some of these mistaken assumptions and how we might remedy their effects on policy making and implementation.

CHAPTER 2: CONCEPTUALIZING WOMEN'S HEALTH

The research reported in this thesis was prompted by my concerns about approaches to women's health in the developing world. It has also grown out of my interest in contributing to a fuller understanding of the social bases of women's health. In this chapter I review literature on women's health in developing countries, showing the limits of the data and of the frameworks which are typically used to understand health and illness - the biomedical and cultural/behavioural models. My focus here is on general empirical and conceptual issues with respect to women's health. By identifying issues which have barely been addressed I show how my research was designed to address gaps in our understanding of the nature and source of women's health problems.

DEFINING WOMEN'S HEALTH PROBLEMS

Reproductive Health

In developing countries the health of women has been constructed mainly in biological reproductive terms. The emphasis in the literature has been on the reproductive and child bearing years of women, highlighting the magnitude of maternal morbidity and mortality in developing countries (Bimal, 1993; Boerma, 1987; Graham, 1991; Kluffio,

1974; WHO Chronicle, 1986; World Health Forum, 1986; U.N., 1991). Maternal mortality rates are as high as 500 per 100,000 live births and are undoubtedly even higher in some regions within developing countries. Among the factors that account for this dismal picture, are the consequences of unsafe abortions, infections and haemorrhage, ruptured uterus (Boerma, 1987; Eades et al., 1993; World Health Forum, 1986), and health service factors, such as ineffective and inefficient medical treatment (Boerma, 1987; Sai, 1986: 318; Sundari, 1992; World Health Forum, 1986). As well, adolescent pregnancy, the number and spacing of children and childbearing over the age of 35 have all been found to be correlated to maternal morbidity and mortality (Sai, 1986; World Health Forum, 1986). Studies have also identified other sociocultural factors, such as cultural practices and aspects of traditional medicine, food and water availability, and education as factors in maternal mortality and morbidity (Bimal, 1993; Boerma, 1987).

As a corollary to the literature, several strategies have been suggested to prevent or reduce maternal morbidity and mortality. For instance, in the mid 1980s it was recommended that member states of World Health Organization (WHO) should designate maternal mortality as one of the global indicators of "Health for All by the Year 2000" (WHO Chronicle, 1986). Community-based health care has been promoted, with the goal of de-emphasizing high technology and curative health services and replacing them with programs that ensure more accessible care which meets the basic needs of the community. Maternal and child health and family planning (MCH-FP) initiatives have become important strategies

for the promotion of women's health (Sai, 1986). The focus on maternal health has led to training for Traditional Birth Attendants (TBAs), the development of appropriate technology for preventing maternal deaths, research on innovative programs and epidemiological research on the incidence and causes of maternal deaths (Ampofo et al. 1977; WHO Chronicle, 1986:179-183; World Health Forum, 1986). In February of 1987 at the International Conference on Safe Motherhood in Nairobi, The United Nations Fund For Population Activities (UNFPA) and the World Bank adopted 'Safe Motherhood,' a policy strategy aimed at improving women's health by preventing maternal morbidity and mortality (Paolisso and Leslie, 1995; Rathgeber and Vlassoff, 1993).

One of the assumptions underlying much research and policy regarding women's health in developing countries is that Third World women are responsible for the rapid population growth which has been seen to impede the pace of development (Adayfio-Schendorf, 1990:3; Benneh et al., 1988; Rathgeber and Vlassoff, 1993). The provision of health and other social amenities has thus been geared towards the control of women's fertility. Embedded within this approach are cultural stereotypes of women as mothers and wives and consumers of health. This stereotype overlooks vital contributions of women as workers, and renders invisible the multiple and complex problems that women face during their long productive years as both mothers and workers (Browner, 1989; MacCormack, 1989; Raikes, 1989; Rathgeber and Vlassoff, 1993).

While it is important to focus on women's reproductive health problems, undue emphasis on this aspect of women's health may undermine concern about other women's health issues. Recent studies have started to assess and criticize the traditional narrow focus on women's biological reproductive health (eg. Rathgeber and Vlassoff, 1993; Raikes, 1989; Paolisso and Leslie, 1995). Researchers have pointed out that the focus on women's childbearing functions has led, at the national level, to a preoccupation with maternal health care services, while at the international level it has led to a "strong focus on women centred population policies" (Rathgeber and Vlassoff, 1993:514). New frameworks for research which consider women's health more broadly, are now being developed.

Other Health Problems

Recent studies on women's health in developing countries have identified physical health problems which are not directly related to reproduction that women experience. Researchers have pointed out that women suffer from Sexually Transmitted Diseases (STDs) including AIDS (Bassett and Mhloyi, 1991; Orubuloye, Caldwell and Caldwell, 1993; Raikes, 1989:448; Santow, 1995) leprosy and tropical diseases such as malaria, schistosomiasis, filariasis, trypanosomiasis (Rathgeber and Vlassof, 1993:513). Women also suffer from various types of cancers such as cancer of the cervix and breast (Okojie, 1994:240 U.N., 1991). Nutritional anaemia, resulting from poor nutrition and lack of food is not uncommon (Lado, 1992:801; Raikes, 1989:448). The health risks associated with

female genital mutilation such as haemorrhage, tetanus and septicaemia have also been documented (Okojie, 1994; Santow, 1995:152).

Violence against women is now recognized as a health problem and researchers are attempting to identify factors which may be contributing to its prevalence in many developing countries (Ampofo, 1993:102-111; Heise et al., 1994; Ofei-Aboagy: 1994). In India and Bangladesh, domestic violence, especially in the form of "dowry murders," is rampant; although the police officially recorded 4,835 dowry deaths in 1990 for the whole of India, the Ahmedabad Women's Action Group estimates that annually, 1,000 women may have been burned alive in Gujarat State alone (Heise, 1993). In Ghana, women are exposed to different forms of violence such as rape, battery and assault (Ampofo, 1993). However, the laws regarding domestic and sexual violence have been found to be insensitive and inadequate to the plight of Ghanaian women exposed to violence.

For the most part, the literature on women's health problems in the developing world has assumed that health problems apart from reproductive issues, generally affect women and men in the same way. Recently, however, researchers have argued that the differences in how men and women experience illness have received insufficient attention. They also point to gender differences in health problems (Rathgeber and Vlassoff, 1993; Browner, 1989; Paolisso and Leslie, 1995; Santow, 1995). These researches note that in addition to the biological differences between women and men, women's socioeconomic and cultural status differs from that of men. These differences influence health risks and define constraints and

opportunities in relation to solving health problems (Paolisso and Leslie, 1995:50). For example, women's activities such as water collection may expose them to particular risk for water-borne diseases, while their firewood collection may expose them to malaria vectors (Rathgeber and Vlassoff, 1993:516). Moreover, while attention to women's physical health problems is, then, expanding to consider issues beyond reproduction, the literature on women's health in developing countries has tended to focus on physical health. Less attention has been paid to the mental health problems of women.

Mental Health

Information on the mental health of women in the developing world is scarce. Smyke (1991) notes that it is difficult to draw conclusions about the mental health of women in the developing world because most available data are not broken down by gender. Stinson (1986:125) has also argued that men's mental health problems may be more easily recognized than women's because men's problems find expression in alcoholism and other relatively obvious disorders while women often suffer in silence. Furthermore, earlier psychiatric observations in Ghana and other African countries perpetuated the myth that mental disorders were not prevalent among either sex, supposedly because the continent was devoid of the stressful living conditions characteristic of western countries (Fosu, 1995:1030). In addition, research on women's mental health may be difficult to conduct because of the stigma attached to those who suffer from mental health problems. For

instance, in Ghana it is almost impossible for people who have histories of mental disorders to find marriage partners, and this may prevent women in particular from talking about their mental health problems or seeking professional help.

Despite the poor documentation on the mental health status of women in the developing world, some general studies do show evidence of greater mental illness among women than previously thought (Smyke, 1991; Stinson, 1986; U.N., 1991). Shaw-Taylor's 1981 study in Ghana found a higher rate of mental illness among female patients than among male patients. The sample for this particular project included female patients from alternative health facilities such as the traditional healing centres where mental illness was found to be higher among women than men. In Sri Lanka, the suicide rate among women aged 15-24 is five times the rate of infectious diseases and 55 times that of deaths related to childbirth (U.N. 1991:93). In other developing countries such as Trinidad and Tobago increasing numbers of women are being found to have some form of mental health problem. It has been found that admissions to hospital for alcoholism increased between 1970 and 1980 from 2.4% to 10.0% of all female admissions, and other forms of drug dependence among women increased by 300% between 1970 and 1984 (Paltiel, 1993).

Few studies have noted variations with respect to social indicators such as sex, age, marital status, education, occupation, socioeconomic status or area of residence (rural/urban) and mental illness. Research conducted in Nigeria (Ebie, 1981), Kenya (Otsyula and Rees, 1972) and Ghana (Shaw-Taylor, 1981) shows a higher incidence of depression, anxiety and

psychosomatic disorders among women than men. Behavioural problems, particularly alcoholism and drug addiction, were identified as predominant among men (Kisekka, 1990:3). The age group most likely to have mental health problems is 21 to 30 in Nigeria (Ebie, 1976) and 30 to 35 in Ghana (Shaw-Taylor, 1981). While Ebie (1976) found the highest mental illness rate among married women in Nigeria, in Ghana, Shaw-Taylor (1981) found higher rates among divorced women, followed by single, separated, widowed, and married women. Danquah (1978), in his study of psychiatric patients in Ghana, found that the highest rate of mental illness was among those who had received some college or university education. Although Shaw-Taylor's (1981) study did not support Danquah's findings, she found the incidence of mental illness highest among the employed, especially professionals. As well, the urban area was found to exhibit a constantly higher rate of mental illness than the rural area in Ghana.

A small number of studies have explored the relationship between social factors and women's mental health in developing countries. Explanations have been sought for the variations in incidence of mental health problems among women. Assael and his colleagues (1972:387-395), for instance, examined psychiatric disturbances during pregnancy among a group of Ugandan women. The researchers found that the social, psychological, economic and cultural circumstances within which these women lived affected their mental health. The researchers identified unsatisfactory domestic, social and economic conditions as contributors to the mental health problems experienced by patients. El-Mouelhy (1990) has

also noted that large numbers of children and other family demands affect the physical and mental health of Egyptian women. In Ghana, Shaw-Taylor (1981) has explored the relationship between psychoneurosis and women's social problems. Sixty-nine percent of the problems identified emanated from the home and work environments. The most frequently mentioned problem that Ghanaian women in this study faced was insufficient money for housekeeping (Shaw-Taylor, 1981:18-19). Studies in other developing countries have yielded similar results. Finerman (1988:167) found that adult Saraguro Indian women in Ecuador encounter stress as a result of fulfilling "excessive and unstable gender role expectations." Kimbal and Craig (1988) made similar findings among women in Borneo in Southeast Asia. They observed a relationship between overwork, and strict Islamic marital and religious obligations and stress among women. Each of these studies points to an association between women's status in society and their mental health.

The information on women's mental health in developing countries, though sparse, does indicate that women experience mental health problems. However, we still know very little about its prevalence among women, or the type of disorders from which they suffer. The factors contributing to women's mental health problems is also yet to be understood.

Sources of Data

As we can see from the above discussion, women's health has traditionally been defined predominantly in reproductive terms, though other aspects of women's health are

increasingly being recognized. Researchers have documented various physical health problems and it is now recognized that women experience mental health problems as well. However, there are few data on the many aspects of women's health in developing countries and this makes it difficult to present a clear and coherent picture of the general health situation of women. Neither have many of the available data been broken down by gender, perhaps because it is assumed that men and women suffer illnesses in similar ways (Raikes, 1989:450). The use of such limited and problematic data on women results in the construction of a partial picture of women's health.

Another significant feature of the literature on women's health is that much of it is based on data from hospitals and health care centres. Relying on data derived from such sources ignores much of the illness that is either unreported or else taken to other healers or sources of advice and care. These include religious healing centres, pharmacy shops, informal drug peddlers and traditional healers such as Traditional Birth Attendants (TBAs). More distant from the models of bio-medicine are, the fetish priests priestesses and herbalists (Fosu, 1995). In Ghana it has been found that traditional medical services, and drugs purchased from local pharmacies and drug peddlers are more frequently used to cure ailments than are the hospitals (Fosu, 1995:1031). This suggests that because many illnesses are not reported in hospitals, data based on hospital visits do not adequately reflect the health problems women may be experiencing in a particular community.

Hospital based data usually record more life threatening illnesses and diseases or maternal mortality. Yet even if they were complete in this regard, mortality data provide only a partial picture of those living and only tell us the major causes of death (Walters, 1991:32); many low level and long term illnesses that women may be suffering from are excluded. Many women experiencing various ailments may accept them as an inevitable part of life, or may not think the health problem is serious enough to merit medical attention. Moreover, women may suffer in silence and not seek treatment because they are unwilling to disrupt household organization (Okojie, 1994:1237), or because they cannot afford care.

Accessibility to health centres is another factor contributing to the inadequacy of the data on women's health. The health infrastructure and services in most rural areas are either non-existent, inadequate, or culturally unacceptable. For example, women may have access to medical care but may avoid it because of the stigma attached to certain types of illnesses. It is now known that tropical diseases such as onchocerciasis probably affect men and women equally (United Nations, 1991), yet the available data show a lower incidence among women. The reason for this is that women are reluctant to report to hospitals with their symptoms because of the social stigma attached to the disease. Women who suffer from these kinds of diseases may be shunned by their communities. They may also be considered unfit for marriage, and in some situations even banished from the community to die alone. This means that women may try to hide the symptoms of the disease or else seek medical care secretly (United Nations, 1991:v).

Much of the available data on women's health also relies on the biomedical categories of medical experts. The data are often categorized in a conventional epidemiological/medical fashion and thus may leave out important aspects of the ways in which women describe their health experiences and the social context of their health. The voice of women themselves, identifying their health problems in their own words is thus excluded.

In sum, we may have a partial picture of women's health problems in developing countries. The emphasis on women's reproductive roles means that we know little about other aspects of women's lives and health. The data are also incomplete insofar as they reflect expert definitions and exclude women's own accounts of their health. The literature also tends to rely on institutional statistics and does not capture problems for which women do not seek care, or at least care from hospitals and health centres. It is not clear whether or how the picture would change if women themselves were asked to define their health problems. This research is a step towards a more comprehensive understanding of women's health in the developing world.

EXPLANATORY MODELS

In addition to the bias in health problems emphasized in the literature on women's health, there seems to be an imbalance in the ways in which health problems are reported and explained. The explanatory models which are emphasized often focus on biological dimensions of disease or else tend to blame people for their health problems, instead of

looking to the wider environment for the root causes of health problems. Such analyses ignore important influences both within the household and the community which can constrain the choices available to women concerning their health. In general, three models have been used by western sociologists to understand women's health - the biomedical model, the cultural or behavioural model, and the social production of illness model. The following are rough sketches of the main aspects of each model, along with the key criticisms each model has sustained. Within each section I suggest some of the implications of each model for understanding women's health in developing countries.

The Biomedical Model

The biomedical model emphasizes the physiological and biological aspect of illness. The focus is on the internal workings of the human body (Doyal, 1995:15). The model has four main assumptions (Mishler, 1989). First, it defines disease as a deviation from normal biological functioning. Second, it assumes that diseases have specific causes. This assumption is the bedrock on which modern western medicine rests. Third, there is the conception that disease is generic; that is, the model assumes that each disease has specific and distinguishing features and is universal to the human species. This means that disease symptoms are assumed to be the same over time and in all cultures. Finally, the model assumes the scientific neutrality of medicine. Physicians are thought to be guided by objective scientific rules and thus unaffected by wider social, cultural and political forces.

The biomedical model has had a powerful impact on western medicine and the general public since the nineteenth century (Mishler, 1989:156). Western medicine has used the biomedical model as a framework for describing and classifying much of the sickness afflicting individuals and for defining treatments. The model relies on the use of drugs and surgery to prevent and cure many diseases, and to alleviate the symptoms of others (Doyal, 1995:15). Following this model scientists have achieved much success in the development of anaesthesia, antiseptics, antibiotics and analgesia which are all very important in the cure of diseases (Doyal, 1995:16).

Although the biomedical model has been successful in curing many ailments, its explanation of the causes of disease is mechanistic and individualistic. It attributes disease to the malfunctioning of the human body which is seen as a series of separate but interdependent systems. Illness is regarded as a mechanical failure of some part of one or more of these systems and it is the task of medicine to repair the damage. Within this paradigm, the complex relationship between mind and body is rarely explored, and individuals are separated from the social and the cultural contexts of their lives (Doyal, 1995:15).

The biomedical approach has also led to the neglect of preventive measures and to an over reliance on the curative model both in the explanation of the causes of disease and in explorations of the different ways in which illness is experienced (Doyal, 1995:16). It also fails to explain why many health problems have remained resistant to treatment, and gives

us very little information about why some individuals or groups are more likely to become sick than others (Doyal, 1995; Mishler, 1989). Yet symptoms and illness occur in people who live within sociocultural settings with distinctive beliefs and ways of life. As Doyal (1995:16) points out, the experience of illness is a product of many complex interactions between the whole person and his or her social and cultural environment. But these contexts tend to be ignored in the biomedical approach. Critics have argued that the causes of illness are more complex than this model presents. Overall, the model is narrow in perspective because it does not consider the wider environment in which people live (Busfield, 1986:28; Mishler, 1989:153).

Despite the weaknesses inherent in the biomedical model, a great deal of prestige is attached to it and it has dominated health discourse in both the developed and the developing worlds. Many doctors in developing countries receive their training in western countries and thus only acquire the skills and knowledge of biomedicine. Moreover, drug companies continue to emphasize a biomedical perspective by promoting pharmaceuticals in developing countries. Despite the rising cost of delivering health care there continues to be strong emphasis on the biomedical model in understanding and treating health problems in developing countries.

Cultural/Behavioural Explanations

This model argues that certain behaviours and lifestyles can expose people to health risks. The focus here has been on how an individual's behaviour or lifestyle, which are thought to be 'voluntary,' affects the individual's health (Blaxter, 1990; Macintyre, 1986:407-8). The emphasis in this model is on how variations in people's habits in relation to smoking, taking drugs, alcohol consumption, diet and exercise can expose them differently to diseases (Morgan, Calnan and Manning, 1988:217).

Cultural/behavioural explanations further argue that groups of people have particular cultural beliefs and behaviours which affect their health. Many examples could be cited from the developing world. For example, it is often assumed that women in developing countries have too many children because of the cultural beliefs about children, and that this explains why they have high maternal mortality levels. Women are also blamed for contracting infectious diseases because of their poor hygiene. Women's lack of knowledge about the nutritional value of various foods has also been cited as the cause of malnutrition among children. Caldwell (1993:125-135) echoes the themes of this model by establishing a connection between maternal education, culture and health outcomes. As well, the model assumes that certain cultural practices such as customary rites and rituals expose groups of people to illness. Cultural practices such as female genital mutilation have been documented to expose women to infections and haemorrhage.

The cultural/behavioural perspective has been criticized for assigning undue responsibility to individuals and placing excessive emphasis on individual and group "choices" thereby "blaming the victim." It does not take into account the limits on the choices that may be available to individuals or groups. For instance, this model does not take into account the fact that many individuals do not have hygienic environments because of their lack of social amenities such as potable water. Neither does it always recognize that poor nutrition is less a matter of education and reversing cultural beliefs than low income and lack of access to land. It does not consider the possibility that high birth rates in developing countries may be attributed to wider socioeconomic factors such as the need for children as forms of social security because of the lack of governmental social security in old age. The social production of illness model, on the other hand, addresses such wider social issues.

The Social Production of Illness

The social production of illness perspective draws attention to the importance of material disadvantage and inequality and emphasizes the social structures within which people live their lives, describing how these structures determine the choices that people can make. The social production perspective focuses on the broader external environment, such as the social, cultural, and environmental factors that produce illness. This model therefore helps to explore the association between health and social position and tells us a great deal about how social situations generate health or illness. It examines the circumstances of

people's lives such as their incomes, their occupations, environmental pollution, poor living conditions, and stressful or dangerous conditions of work.

Social indicators such as social class, sex, marital status, age, ethnicity and area of residence have been consistently associated with health and illness in studies in developed countries. Overcrowding in homes and high levels of pollution in the area of residence, for example, are known to contribute to high rates of respiratory diseases (Doyal, 1979; Smith, 1989:122-141). Many studies have also shown that people's occupational settings produce illness. For example, studies in occupational health and safety provide persuasive evidence that links work environments and the labour process to illness and disease and points to basic contradictions between profit and safety (Doyal, 1995; 1979; Navarro, 1986; Waitzkin, 1983; Novek, Yassi and Spiegel, 1990).

This perspective has also been used to explain why people adopt unhealthy behaviours. By looking at the structural roots of individual lifestyles, a 'blame the victim' stance is avoided. Some people respond to stressful life and work conditions by smoking or consuming alcohol, for example. However, Blaxter (1990) has argued that social circumstances such as poverty and lack of social support may be more important in influencing health than are unhealthy behaviours. Thus, although people's behaviours and beliefs are important in considering their health, it is more relevant in policy formation to consider the circumstances under which people live.

The social production of illness perspective has been used to analyze how the relationship between developed and developing countries affects the health of the people in developing countries (Doyal, 1979; Lado, 1992; Navarro, 1984; Ray, 1981; Sen and Grown, 1987; Turshen, 1984). Writers have traced how colonialism and later relationships between developed and developing countries produced illnesses in developing countries. A core argument from the social production of illness perspective is that social conditions created by the colonial system and the activities of multinational corporations often predispose people to a number of health hazards in the developing world. In some of the literature, the focus has been on the importance of women's agricultural production and how women have lost their land as a result of colonial policies. Doyal (1979:22) has described how relations of production between developed and developing countries have produced many illnesses. According to Doyal (1979), the establishment of colonialism as an economic social system in East Africa involved the deliberate transformation of the socioeconomic organization of the colonial territories to complement the development of the 'mother country.' The introduction of cash crops and migrant labour led to a reduction in the production of nutritional food. As a result, the quality of food consumed especially by women and children worsened. Malnutrition among women has been found to cause small and abnormally-shaped pelvises which make childbirth more difficult and dangerous. Increased economic hardship and the disintegration of personal and social relationships under the migrant labour system also produced new forms of mental disturbance among rural women (Doyal, 1979).

Some of the literature has examined how the relationship between developed and developing countries has exposed people in developing countries to different forms of exploitation and environmental hazards. Elling (1981) argues that the nature of the economic relationship between developed and developing countries creates serious occupational health safety problems for developing countries. The point of Elling's argument is that in their rush to attract industries, developing countries have used their resources to attract multinational corporations in many ways; they have provided these corporations with cheap labour, ready and cheap raw materials, polluting havens and in some cases financial capital (Elling, 1981:216). Although multinational corporations establish jobs in developing countries these jobs are often unskilled and low-skilled and they pay low wages. In Asia for example, many women work in 'sweat-shops' producing lace, low-cost clothing, computer chips and toys. Many of these workers are subjected to a high degree of exploitation and work under very poor conditions. The work is usually monotonous and hazardous to their physical and mental health and many of them are increasingly exposed to hazards such as dangerous chemicals and dust, inadequate lighting and other side effects of agricultural and industrial development. Exposure to pesticides and fungicides have been associated with cancer, miscarriages and birth defects (Okojie, 1994:1241; World Federation of Public Health Association, 1992:201-223).

The social production of illness model has limitations. It emphasises social factors as predisposing people to illness and assigns little responsibility for the outcome of health

on the individual or biology. The concept of the social production of illness assumes that the factors which make people ill are external to them and are usually beyond their individual control. In essence, the model assumes that individuals do not have a hand in the creation of the conditions that make them ill. It is important however to note that biology and individual behaviours are also important factors in health and illness outcomes. Women's biological make up and their own behaviours and decisions are certainly important factors determining their health status. Nevertheless, there are many external factors both within the household and outside it which could either enhance or constrain the choices women make concerning their health and in this study my emphasis is on these factors.

Despite such limits, the social production of illness perspective is broad in scope and promises to add to our knowledge of why people fall ill. It complements the other models, which have more often been a focus of attention. By also understanding the way in which illness is socially produced we will have a more comprehensive understanding of health and illness.

Each of the three models used to understand health - the biomedical, cultural/behavioural and social production of illness models - lead logically to a particular set of health interventions. Often these interventions, like the models themselves, contradict or compete with one another however, that it may be helpful to try and find the right balance between the models and to refrain from viewing them as mutually exclusive. Macintyre (1986:409) has pointed out that the distinction between explanatory models of health is

nevertheless very important since each has its own implications for the kinds of medical and social policies that must be adopted to solve health problems.

In developing countries, significant emphasis is still placed on the biomedical model of health and illness and individualistic explanations of the causes of health problems continue to dominate research and policy. Much less attention has been paid to the structural bases of ill health and to the ways in which health is linked with the social and material circumstances of people's lives. Yet this is not to argue that social production analyses have been entirely absent. As the next section indicates, there is a growing body of literature that seeks to document the social production of women's health in the developing world.

THE SOCIAL PRODUCTION OF WOMEN'S HEALTH

In recent years researchers have started to develop a gender framework for the analysis of women's health. This emerging 'feminist epidemiology' (Doyal, 1983) has introduced a gender dimension to the concept of the social production of health and illness. Many recent studies focus on gender as a basis for the development and explanation of the social structures that account for women's health status. This branch of the literature argues that women's health is a reflection of their subordination as manifested in the conditions under which they live and specifically explores the social, economic and political bases of women's health problems (see for example Doyal, 1979; Doyal, 1995; Payne, 1991; Penfold, 1983; Blaxter, 1990; Walters, 1993). Feminist proponents of the social production of illness theme

have argued that women's activities are so numerous and intertwined with their health that it is impossible and unwise to separate them (Doyal, 1995:21). They have thus suggested that women's health must be understood within a holistic framework. This framework includes women's productive and reproductive contributions, their relationships with others and their views of themselves. The cumulative effects of women's activities are understood to determine to a great extent their health status throughout their life cycle (Doyal, 1995:22). Finally, this approach places the responsibility and power for dealing with health problems in the hands of women themselves (Rathgeber and Vlassoff, 1993:519). Taken together these considerations seem to present a more comprehensive representation of women's health than has traditionally been available. In the section that follows I adopt a social production of illness model to consider the various spheres of life in which women play roles. In this connection we need to look at paid labour and the household, where domestic work is performed and where biological reproduction occurs. Although much of the work in this area has been done in the west I will also incorporate literature on women in developing countries which has been written from this perspective.

Domestic Work: Social Reproduction

In developing countries, as in most parts of the world, women are primarily responsible for the maintenance of the household. Women's daily activities for example, involve fuel and water collection; cleaning; caring for children, husbands and other

dependents; and processing, preparing and cooking food (Momsen, 1991:37). Domestic work has been largely invisible and regarded as 'natural,' and as such is considered 'good' for women. Many studies have questioned this assumption and have tried to make visible women's work in the home (Armstrong and Armstrong, 1984; Doyal, 1995; Luxton, 1980). These studies have looked at the nature and conditions of domestic work activities. In many western countries, work in the home has been identified as very isolating. The main characteristics of domestic labour are its "open-endedness and its sheer volume" (Doyal, 1995:28). Domestic work is unpaid, repetitive, and generally has a low status in society. Childcare in particular can be exhausting and demoralizing.

Time use studies have tried to measure the number of hours women spend on various work activities. Although there are widely varying estimates of time use these studies have given a general idea about how women use their time. It has been found that generally, women work longer hours than men and have less leisure time. It is estimated that Canadian women spend an average of 4.1 hours per day compared to 1.9 hours for men on unpaid work activities such as domestic work, childcare and shopping (Harvey, Marshall and Frederick, 1991:27). Recent statistics on women's work in developing countries indicate that on the average women work for about 12 to 18 hours a day (compared to 10 to 12 for men) engaged in multiple roles within their families as caretakers, educators, health promoters and income earners (Agarwal et al., 1990). In eastern Uganda for example, women spend about 15.5 hours a day engaged in activities such as collecting firewood and water, caring for children

and preparing food (Mwaka, 1993:47). At certain times of the year, women spend more time on these activities. During the dry season for example, they may have to walk longer distances to get water (Momsen, 1991:39).

Many of the studies in the west have focused on the psychological risks that women may be exposed to in the household. It has been found that full-time homemakers are more likely to say they are dissatisfied with their lives or to suffer from depression (Brown and Harris, 1978; Nairne, 1984). Other studies have pointed to the fact that women do not receive the emotional support they require to cushion them against depression, adult daughters give more emotional support than adult sons or partners (Miles, 1988). In the study by Miles, half of the women mentioned unhappy marriage as part of the cause of their depression. Men, on the other hand, mentioned work and health problems (Miles, 1988:28, 42).

Motherhood can also be detrimental to women's health, particularly for those women who are undernourished, overworked but give birth to many children (Doyal, 1995:24). The demands of childcare place both physical and psychological stress on women. A study in the United Kingdom found that mothers who bring up their children alone were consistently found to have worse health than women in households with two parents. Apart from money problems they encountered as lone parents, women mentioned the heavy responsibility involved in caring for children (Popay and Jones, 1990). Domestic work seems to have the severest effects on poor women with young children (Graham, 1993; Payne, 1991).

It is difficult to distinguish between women's domestic and productive work in developing countries because in many cases both activities take place in the same environment. Despite these analytical problems, efforts have been made to document domestic work activities. The focus has generally been on the impact of domestic work on women's physical health, with emphasis on the drudgery involved in the work activities of women in developing countries (Agarwal, 1986; Buvinic, Lycette and McGreevey, 1983). The literature highlighted the nature of domestic work activities in light of few or no labour saving devices, a luxury which most women in developed countries enjoy.

Many women in developing countries are responsible for both the production and processing of food. They are also responsible for the collection of fuel, often fuelwood (Ardayfio-Schandorf, 1993:15; Momsen, 1991:38). Water collection from wells, streams, rivers or public pipes is usually the sole responsibility of women (Doyal, 1995:31-32; Mwaka, 1993). The sheer time involved in these activities and the energy they demand leaves women exhausted, and contributes to health problems. Food preparation in many developing countries, for instance, can be time consuming, energy draining, and can expose women to certain accidents. The traditional method of grinding grain in the Gambia involves pounding grains repeatedly in a mortar with a heavy pole. This activity causes backaches, tiredness and sore hands among Gambian women (Barrett and Browne, 1993:53). In times of drought women in India are known to go without sleep looking for water in the night, carrying heavy vessels to ensure that they get enough water for their households. Lifting

heavy loads has been associated with prolapsed uteruses (Kishwar, 1984:112). Accidents such as falls and injuries from cutting tools are known to occur frequently. For women living in poverty, working long hours without food may sometimes worsen their health status while at the same time improving that of their dependents (Mebrahtu, 1991; Raikes, 1989:454).

The literature on the impact of domestic work activities on women has further examined caloric depletion in women as a result of engaging in domestic activities (Kabeer, 1991; Rodda, 1991:84). Rodda found that water collection depletes more than a quarter of the energy gained from women's daily food intake. In the Gambia, it has been estimated that women use 1,800 calories during the six hours that they pound enough coos - the staple grain - for their families (Kabeer, 1991:27). In the same study, Kabeer (1991:29) found that Gambian women expend more calories than they consume when they combine their domestic work with heavy agricultural work. The weight loss resulting from insufficient caloric intake has been argued to have serious health consequences for women. It has also been estimated that women carry loads as heavy as 35 kilograms for distances of about 10 kilometres daily (Agarwal, 1986:17). In addition, women who rely on forms of fuel such as biomass and wood are exposed to smoke pollution (WHO, 1984). Domestic work is thus detrimental to the health of women in developing countries.

Women's Role in Production

Another area of women's lives that has received some attention in the literature has been their productive activities. Officially 40% of the world's women are in the labour force, though it has been argued that this is an underestimation (United Nations, 1991; Young, 1993). Women not only engage in productive work in the formal labour sector; many women especially in the developing world work in the informal sector too. Researchers have pointed out that some of the produce women harvest from their farms is also sold for cash (Jiggins, 1989; Lado, 1992; Lowenson, 1991; Raikes 1989). Women have also been shown to engage in a wide variety of work roles ranging from the production and sale of handicrafts to work as traditional healers or birth attendants (Browner, 1989; Lubanga, 1991). Documentation about women's various productive activities in developing countries, and about the conditions under which women work, is increasing. This is providing the basis for a fuller understanding of the links between women's work and their health.

In the west, where more women work in the formal labour force, employment has been found to have both positive and negative effects on their health. Macro level studies have focused on the health effects of working outside the home by comparing homemakers and women who are employed. Work outside the home has been found to improve the general well-being of many women because it has given them greater access to the basic necessities of life. It has also enhanced their social status and given them a wider social support network (Doyal, 1995:24; LaCroix and Haynes, 1987). Even the most routine paid

work has been found to protect women against depression (Brown and Harris, 1978; Walters, 1993).

The health risks of women who work outside the home have also been emphasized. The literature has identified that what is regarded as "women's work" may involve occupational risks (Doyal, 1995:24-25). Also, women face the problem associated with the "double day." Married women with children constitute a large percentage of the women joining the labour force. Most of them continue to retain the majority of household and parenting responsibilities. The double burden of paid and household work has been found to make women physically and emotionally exhausted. The situation is worst for women who have little material and social support (Doyal, 1995:24; United Nations, 1991:81-82). So although waged work can be beneficial to women, certain factors will determine its impact on women's health. Domestic circumstances such as the marital status of a women, the nature of the division of labour in her household, her age, number of dependants, her skills and the nature of the job itself will all influence her health (Arber et al., 1985). Some studies, for instance, have pointed out that part-time work has been associated more closely with better health than full-time employment (Hall, 1992). This is especially true for women of lower socioeconomic groups with young children (Arber, et al., 1985). Thus the issue is not whether paid work is beneficial or harmful to women, but rather what types of jobs and working conditions are beneficial or harmful to women (Doyal, 1995:155). For a broader

understanding of the impact of waged work on women's health, more of the above factors will have to be considered in research.

In developing countries, discussions of the impact of productive work activities on women tend to have a slightly different focus. In contrast to the literature on women's health in developed countries, there appears to be more emphasis on physical health. The studies are few in number, but they document occupational health hazards and show that women's productive work can have a severe impact on women's physical health in developing countries (Khan, 1991; Lowenson, Paolisso and Leslie, 1995; 1991; Smyke, 1991, 104-106; Turshen, 1991). Work related health problems such as burns, and health risks such as smoke pollution and exposure to toxins have been identified. Agricultural activities like weeding, transplanting and threshing involve working for long hours in uncomfortable positions such as bending from the waist. This leads to chronic back and leg problems. The technology related to cash crop production has also been found to expose women to health risks. Much of the work women do on farm plantations involves hand labour such as picking, sorting and harvesting. This exposes women to pesticides for long periods of time endangering them and their children. Byssinosis or "brown lung" has been found to occur in workers in the clothing industry, a sector that is dominated by women (Paolisso and Leslie, 1995). Women who work in electronic assembly lines develop eye problems after only one year of working (United Nations, 1989).

The impact of colonialism on women's work and health has been the focus in some of the literature (Doyal, 1979; Lado, 1992). Lado (1992:800) examines the effect of colonialism on food production. He considers women's roles and activity patterns within the household in terms of their rights, obligations, allocation of resources and responsibilities and division of labour in selected African countries. He argues that rural women in Africa became marginalized in the subsistence agricultural sector and this reduced their productivity and control over resources. Their work burden also increased and these changes have affected their nutrition and health. Doyal (1979:101-104) makes similar arguments. She suggests that the establishment of the colonial system, with the destruction of indigenous modes of production and cultural patterns and their replacement by new forms of social and economic organization, compromised the health of the indigenous people.

More recently, the gendered nature of the Structural Adjustment Program (SAP) in various developing countries is being documented (Sparr, 1994:vi). Structural Adjustment is a term used to describe the "conscious" efforts countries make to change the economic conditions in their society. Most often, international finance agencies such as the International Monetary Fund or The World Bank require that developing countries seeking loans from them adopt Structural Adjustment Programs. The term now refers to the processes by which developing countries are reshaping their economies to become more market oriented. SAP also involves deregulation, removal of subsidies, and less protection from governments (Sparr, 1994:1). In analyzing the impact of SAP on women, case studies have

been conducted in countries such as Nigeria (Elabor-Idemudia (1994:134-159), Egypt (Hatem, 1994:40-56), Ghana (Manuh, 1994:61-72), and Sri Lanka (Jayaweera, 1994:96-11). These studies look at women in their own right, not only in their role as mothers. They focused on aspects of women's lives such as employment and other income-generating activities. In Ghana, for instance, Manuh (1994:61-72) documents the ways that Ghanaian women have been very vulnerable to the effects of SAP. For example, retrenchment exercises have affected women more than men because of women's generally lower educational status and their concentration in many of the sectors targeted for redeployment. Furthermore, for women who are heads of households, the loss of a job means that the welfare of their families is affected adversely, and this affects them psychologically. SAP implementation has also worsened the situation for women traders since they now face increased competition, higher prices and continued low purchasing power given the low general level of income.

The nature and significance of women's roles and the ways in which these roles affect women's health has been explored in some depth in developed countries. These issues are now being explored in developing countries as well. Literature that conceptualizes women's health from a gender perspective in the developing world is, however, sparse. Even where this has been done, the emphasis has generally been on the physical strains of women's work activities. There have been few comprehensive, coherent or in-depth studies examining how women's roles and responsibilities affect their health. Such questions generally surface only

as cursory commentaries in the larger body of literature on women in developing countries. The literature contains only hints and allusions to the connection between women's health and lives. The complex and significant links between women's lives and their health have yet to be adequately established. The task is not only a matter of documenting the work activities in which women are engaged; what we need to know is the cumulative effect of these work activities on women's health on a day-to-day basis.

While the social production of illness perspective presents a fuller picture of women's health status, complementing other models of health and illness, the bulk of the literature on women's health in developing countries does not use this approach. The emphasis in the literature tends to be on the physical/biological with a few selective environmental explanations for women's health problems. The result is that these analyses have produced only partial information on the health status of women. Much of the literature fails to present analyses that situate women's health within the social context in which women live their lives on a day-to-day basis. As well, since the literature is usually written through the eyes of experts, little is said about women's actual experiences. The studies thus do not take into account women's own definitions and constructions of their health.

THE RESEARCH PROBLEM

The research reported in this thesis grew out of a recognition of the gaps in research on women's health in the developing world. In reviewing the literature on women's health

in developing countries and in Ghana in particular, I have pointed out that the emphasis has been on reproductive health. I have shown that where other health problems have been recognized and explored, the main focus has been on women's physical health. Thus we know very little about the mental health status of women in developing countries. We know even less about the health of women who do not seek health care from formal sources. The explanatory models used in the available literature have generally not sought to explore the day-to-day lives of women or to consider how women's daily activities prompt ill health. Indeed, Doyal (1995:21) goes so far as to suggest that for us to adequately understand the health status of women, traditional epidemiological methods have to be turned upside down.

The thrust of her argument is expressed in the following words:

Instead of identifying diseases and then searching for a cause, we need to begin by identifying the major areas of activity that constitute women's lives. We can then go on to analyze the impact of these activities on their health and well-being.

Another feature of the work to date is that it has generally ignored women's own concerns about their health. For the most part, it is the views of policy makers, professionals, non-governmental organizations and academics rather than the concerns of women in general that have been voiced. We do not know if these views reflect the priorities of 'ordinary' women.

The research presented here was prompted by these observations, it starts with basic empirical questions:

- a. What are the main health problems experienced by women in Ghana? Are reproductive health problems at the forefront of their minds? What other problems do they experience? Do these include mental health problems?
- b. What health problems do Ghanaian women worry about?
- c. How do Ghanaian women understand and explain their health problems? Do they link them with women's roles, the work they do to sustain their families and earn money, their relationships with men and the expectations which shape women's lives?
- d. How do Ghanaian women cope with their health problems? What resources can they count on? Do these help?
- e. What suggestions do the women have for changes which might help to improve their health?

Beyond documenting the health problems women report and the health problems that worry them, my research aims to capture women's own definitions and perspectives. By looking at the ways in which women understand the health problems they experience, we see how women's health is linked with gender roles, work, family, and the expectations which shape women's lives. Women's own words may provide us with clues about the social production of women's health, that is, the ways in which women's health is influenced by women's roles in biological reproduction, social reproduction and production.

Because the aim of the research is to consider possible links between women's roles and their health, it is crucial to start with an understanding of the nature of women's roles. The next chapter outlines features of women's lives in the developing world with special reference to Ghana, the site of my field research.

CHAPTER 3: WOMEN IN GHANA

This chapter presents a picture of the general situation of women in Ghana. It sets the context for the research and outlines aspects of Ghanaian society that influence women's day-to-day lives. It thus provides a background to the interviews with women which are the core of the research reported here. Four main themes will be discussed in this chapter. First, I will examine the sociocultural images of Ghanaian women and show how these images inform how Ghanaian women are perceived and how they perceive themselves in society. I will also explain how perceptions of women affect women's status in Ghanaian society. Secondly, I will consider women's work activities both at home and outside the home. In looking at women's activities in the home I will use the concept of "the household" as a framework for understanding the gender division of labour and women's work loads. I will also look at the constraints women face in performing their income-generating activities. Thirdly, the chapter examines state policies and programs, particularly the Structural Adjustment Program (SAP). I show how state policies and programs are informed by gender ideologies and consider the impact they have on women. I conclude the chapter by discussing the general health situation of women in Ghana and outlining how women's productive and reproductive activities have the potential to influence women's health.

To understand women's lives in Ghana it is important to examine the interaction between the reproductive and productive roles of women and to consider other social and cultural factors that impinge upon women's lives. This framework enables me to analyze many aspects of Ghanaian women's day-to-day lives. The analytical focus here is on gender relations. I will discuss the consequences for women of the structures which construct gender divisions and attribute tasks, responsibilities, resources and power to men and women differently (Kabeer, 1992:108). Beneria and Roldan (1987:11-12) provide a broad and detailed definition of gender construction:

a network of beliefs, personality traits, attitudes, feelings, values, behaviours, and activities differentiating men from women through a process of social construction that has a number of distinctive features. It is historical; it takes place within different macro and micro spheres such as the state, the labour market, schools, the media, the law, the family-household, and interpersonal relations; it involves the ranking of traits and activities so that those associated with men are normally given greater value. Ranking, and therefore the formation of hierarchies, in most societies is an intrinsic component of gender construction.

As this broad definition implies, analyses of gender must be holistic because gender is socially constructed simultaneously with other social relations.

In this discussion, I identify various spheres of Ghanaian women's lives, and activities, and outline key state policies, in order to highlight the repercussions these have on women's health. I start the discussion by examining how women are perceived in the indigenous categories of thought in Ghanaian societies¹. This section will help explain how certain social structures in Ghanaian society come to impinge on women's lives. In instances

where data are particularly sparse I will draw on studies in other developing countries in Africa.

SOCIOCULTURAL PERCEPTIONS AND IMAGES OF WOMEN IN GHANA

In Ghana, as in other societies, a set of ideas about women determines how women are perceived and defines the expectations society has of them. Some of these notions are reinforced by religious beliefs and practices. Prevailing ideas about women influence the ways women perceive themselves and, in turn, shape their conduct. They also inform the ways men behave towards women and the kinds of state policies that are made in relation to women.

Some ambivalence characterizes cultural ideas about women in traditional Ghanaian societies. On the one hand, women are respected for their procreative powers and nurturing role, as these enable them to contribute to the continuity of society through childbearing and childrearing. On the other hand, and more prominently, women are regarded as the perpetrators of evil and misfortune and are thought to assume the guise of witches. They are also regarded as the polluters of the sacred (Hackett, 1994:65). Menstrual blood and other bodily emissions such as urine and spittle from women are culturally regarded as "dirty" "spiritually charged" and "polluting" (Assimeng, 1989; Opoku, 1978). In some societies the vagina is regarded as mystical, polluting and highly charged spiritually, an "object" which

could be evoked to make a curse effective. In other societies it is described with obscene imagery.

Cultural and religious perceptions of women are generally surrounded with some mystery and fear. For example, Zahan observes that among the Bambara of Mali there is a relationship between woman and "night" or "darkness" because women are seen as more "enigmatic and unfathomable than any other creature" (Zahan, 1979:95 in Hackett, 1994:65).

Zahan (1979:95, 114) summarizes the general perception of women among the Bambara:

Like the earth, woman is inert and passive. Like water, she is multiform and changeable and does not let herself be mastered. Like the night and the shadows, woman is difficult to fathom, and like a cavity or hollow, she does not allow herself to be grasped.

Among the Bambara it is also believed that women do not know how to impose limits on their words and thus speak too directly (Zahan, 1979:114 in Hackett, 1994). Zahan's observations are applicable to Ghanaian societies as well. In Ghana prevailing beliefs hold that women are quarrelsome, unpredictable and fickle minded. Women are said to think just like fowls. They are also considered to be greedy, vindictive, manipulative and potentially dangerous. Women are generally regarded as "human snares" or "traps," cleverly using their sexuality to entice men or manipulate them and bring about their downfall, or for their own selfish gain. The phrase "fear woman and save your life" is a common saying among men in Ghanaian societies. Such phrases are also inscribed on passenger trucks and reflect themes which are portrayed in many Ghanaian highlife songs ².

Gender ideologies also underlie traditional customs and practices. Right from birth, Ghanaian culture instils the idea of male superiority and female inferiority into the psyches of boys and girls. Cultural practices such as puberty rites for young women reinforce these notions and emphasize the importance of meeting men's needs (Opoku, 1978:122-123; Brydon, 1985:117-121). During a puberty rite, a woman is taught to look appealing to men always and to be subservient to her husband and to men in general (Nukunya, 1992:44-45). It is also stressed that childbearing is the most important role for a woman and that childlessness is the greatest calamity that can befall a woman. A barren woman becomes an outcast and is looked upon not only with pity, but also with malice. Women are taught to be hard working, to be up and doing all the time and never to complain. Complaints are taken to be a sign of rebellion or laziness and are therefore "unwomanly."

Marriage gives a husband exclusive rights and claims to the sexual and domestic services of his wife. The woman, on the other hand, does not necessarily enjoy such rights from her husband (Oppong, 1974). Among the Anlo, for example, it is inconceivable for a married woman to refuse to have sexual relations with her husband. Sexual intercourse is a marital duty and a woman's refusal could lead to divorce (Nukunya, 1992:43-44). It is traditional practice to counsel newly-married women never to refuse sex, except at the times that they are menstruating. Obviously this limits women's control over their sexuality.

One of the more extreme measures used to control women's sexuality is female genital mutilation,³ which is still practised among certain ethnic groups in Ghana (Osei,

1988, in Ardayfio-Schandorf, 1990:403). Underlying this practice is the assumption that virtuous women are sexually passive and are not supposed to express sexual desires or enjoy sex. The aim of female genital mutilation is to remove the latent sexuality among girls and to ensure that girls remain virgins until marriage. Since women's genitalia are regarded as unclean, the practice is also viewed as a purification rite (Dolphyne, 1991:34-40). Marriages between older men and younger women are also said to be promoted as a result of the frigidity girls supposedly acquire after circumcision (Apesemah, 1987).

Even though Ghanaian societies are changing rapidly, the hold of traditional notions remains strong. Women are still expected to conform to traditional expectations. In fact, women themselves often accept traditional ideas and roles while those who question them face strong social pressures and disapproval. For example, it is expected that women will marry and have children. A single woman is perceived by men to be difficult and selfish, and by women to be immoral and intent on seducing their husbands (Dinan, 1983:344). These social expectations and sanctions affect all aspects of women's lives and shape how they manage their lives on a day-to-day basis.

THE HOUSEHOLD

Focusing on the household will help us understand the nature of domestic work and the sexual division of labour within the household (Beneria, 1982:xii)⁴. The household is important because it is the point at which reproductive and productive relations intersect. It

serves important functions such as biological and social reproduction including socialization and nurturing, and it is the site of fundamental decision making. The household is also the primary site for the structuring of gender relations (Charles, 1993:168; Townsend and Momsen, 1987:40). In 1988 about thirty-five percent of married women lived in polygynous relationships (Ghana Statistical Service, Ghana Demographic Health Survey, 1989). A newly-married woman often moves to live with her husband's extended family which may include her co-wife/wives and her husband's mother, step-mother or both. Such extended family households are often large; they may be made up of three generations and may include ten to even twenty members. Among the Ashanti, however, Abu (1983:160) argued that common residences were only possible for people in monogamous marriages. Most men who had more than one wife did not live with any of them. Among the Dagomba and the Ewe, on the other hand, it is common to find co-wives living in the same household as their husband and learning to interact peacefully with each other. Except for royal marriages, polygyny has been associated with separate residences for spouses among the Ashanti.

Emotional tension and stress as a result of misunderstandings and quarrels among members characterize many polygynous households. The basic pattern of co-wife relationships is jealousy. This theme is widely recognized among Ghanaians and is expressed in many traditional songs (Asante-Darko and Van Der Geest, 1983:242-254). Conflicts among co-wives are frequent. A first wife may be angered by the fact that the man's

resources must be shared between her and a new wife. In a study done among women in the fishing village of Winneba, Hagan (1983:198) pointed out that conflicts between spouses and co-wives were sometimes caused by the fact that a man's catch of fish would have to be shared among co-wives.

In addition to conflicts and jealousy between co-wives, tension between in-laws is also very common in many Ghanaian societies. This is most often highlighted by misunderstandings between daughters and mothers-in-law. It is said that "the typical witch is the husband's mother or sister and vice versa" (Nukunya, 1992:20). This complicated marriage situation is reflected in the common saying among Ghanaian women that "marriage is never sweet when one's mother-in-law is alive." Education and wealth are often essential factors in conflicts between a woman and her in-laws. In many cases, it is family members who support a son in school. However, after he has completed school and found a wife, family members often feel neglected by their son; they may begrudge the fact that he and his wife are living comfortably as a result of the education they financed. The resentment generated by this situation sometimes leads to accusations and counter-accusations, which eventually lead to accusations of witchcraft. There are instances where powerful family members or mothers-in-law succeed in getting rid of their son's wife altogether (Nukunya, 1992:20-21). Conflicts also arise when a mother feels her son is not being adequately cared for by his wife or when she is not in favour of or dislikes the ethnic background of the woman her son has married.

Conflicts with in-laws can also be explained by the ways in which marriage is contracted in Ghanaian society. Marriage is often considered a group affair, that is an alliance is understood to take place between families and not individuals (Nukunya, 1992:39). Mothers of suitors play an important role in the marriage contract. Although the situation is changing, many young men still seek the consent of their parents before taking a wife. Mothers-in-law give advice, take care of their grandchildren, and are usually entitled to visit their sons any time they wish. This often leads to disagreements as married women regard such acts as intrusions on their lives. In most cases, however, married women strive to have good relationships with their mothers-in-law because this is the only way to have a peaceful marriage.

Social Reproduction: Women's Work Activities in the Household

Women in Ghana are traditionally responsible for the maintenance of the household. Women's roles include making sure there is enough fuel, water and food. Their responsibilities also include childcare, care of their husbands, and care for disabled and aging relatives. The size and composition of the household, the ages of children, seasonal food and water shortages, work pressures and housing conditions all affect the burden of work on women (Momsen, 1991:42). There is usually cooperation among co-wives for the management of the household and care of children, but in households where co-wives do not always agree, cooperative work is less possible.

In their analysis of the 1987-88 Ghana Living Standards Survey Statistical Abstract, Hood et al. (1992:142) observe that women's work loads are 15 to 25% higher than those of men. The main cause of this disparity is the disproportionate burden of household work activities. Women were found to spend 20 hours per week on domestic work; men spent five hours per week. The long periods of time women spent on domestic work took time away from their income-generating activities (Ardayfio-Schandorf, 1993; Hood, 1992:141). There are, however, variations between regions in how women allocate their time. During her study, Ardayfio-Schandorf found that female farmers and traders who lived in a savannah village spent an average of 3.5 a day hours on economic activities with the remaining 10.5 hours used for mainly domestic activities. In a fishing village, women spent about 6.3 hours on income-generating tasks, mainly fishmongering, while in a forest village women spent approximately two hours per day on income-generating activities. When food supplies were stable, women in the forest village devoted about 6.5 hours a day to cooking (Ardayfio-Schandorf, 1993:22-23). A lot of this time is used in processing the food for cooking.

Studies in other African countries also point to the long hours spent on domestic tasks. For example, one study in Nigeria found women in Yorubaland spending between four and six hours per day on average on the preparation of meals (Ardayfio-Schandorf, 1983). In Uganda, many women spent more than 15 hours each day in specific household tasks. These tasks were often combined with childcare, a constant responsibility throughout the day and night (Mwaka, 1993:46-51).

In rural areas, wood is the main source of fuel and it is incumbent upon most women to ensure that there is an adequate supply of fuel for household requirements ⁵. The process of collecting fuelwood in Ghana is usually difficult and time-consuming. Environmental degradation has made it even more difficult for women to gather wood (Ardayfio-Schandorf, 1993:15; Hood et al., 1992:141). The collection of fuelwood involves cutting down huge trunks of trees and splitting them into smaller pieces with axes or machetes, and then cutting, splitting and gathering the wood. Most often, women have to travel long distances into the bush or the forest since wood cannot be collected on other people's farms. Women often walk more than eleven kilometres a day to obtain fuelwood.

Potable water is still a luxury to many Ghanaians. In 1995 only 56% of the population had access to safe water: seventy percent of people in urban centres and just 49% of rural people (UNICEF, 1996). It is the responsibility of women to collect water for drinking, sanitation, washing and brewing the local beer "solom" or "pito" or the local gin "akpeteshi" ⁶. To collect water women again have to walk long distances. In order to reduce the number of times they have to go for water, women carry huge bowls or containers. In the dry season when water becomes even more scarce, women spend long hours simply looking for water. They dig holes in the dried river or stream beds and wait for the water to rise up. It can take several hours to collect a bucket of water and women often spend the whole night awake waiting for water to rise up the water table. Tap or well water can be bought but many women cannot afford it.

Women have few labour saving appliances in their homes. Most wash clothes by hand and this requires that they keep their hands in harsh detergents over long periods of time. Cooking pots and buckets are cleaned with plantain leaves and ashes, or with earth if soap or steel wool is too expensive. These substances can be harsh on women's hands. Women sweep their homes, rooms and large compounds with short brooms. This is a demanding process requiring women to bend over or squat for long periods of time.

To maintain their households, women produce a variety of food crops in their backyards or their farms. Portions of these crops are sold for cash to buy items such as soap, salt and fish, or bartered for other food items such as fish. The rest of the crops are stored for use at home. Many women also raise poultry and other animals such as goats and sheep, some of which are used for the household, especially on festive occasions. Most of the livestock, however, is preserved for sale for cash in times of dire need, for instance when a member of the family falls ill or when there is a death in the family. It takes time and energy to look for feed for the livestock every day and when there are no children to help with this task, it too may become the responsibility of the woman.

Food processing is another demanding and time-consuming task for women. Harvesting and transporting crops home is a difficult and strenuous job. It involves carrying heavy loads of corn, cassava and other food crops from the farm to the house. These foodstuffs are then boiled, dried, pounded or grated. Food is usually processed and cooked from scratch: pepper is ground on a stone and soup prepared; cassava is cooked and pounded

in a mortar with a pestle; and "banku", "amawoe" or "akple" ⁷ is cooked daily because there are no refrigerators for the preservation of food.

Most of women's work activities are combined with childcare and the care of other dependents such as their aging parents and the aging relatives of their partners. It is common to see women caring for children at the same time they are also engaged in income-generating activities.

Certain activities are considered to be men's work, particularly tasks that are thought to involve great physical exertion (Nukunya, 1992:99). For instance, felling trees, clearing bush and burning off bush to make land ready for planting are tasks usually done by men. Making yam mounds is also considered a man's task, but nothing prevents women from doing this, and some women do it too (Brydon, 1985:110). Men are responsible for building, thatching and making renovations to the house. They also hunt for meat in the bush or catch fish in the sea or rivers (Nukunya, 1992:99-102). Because of the division between men's work and women's work, men who help with the tasks which are supposed to be performed by women have to do so in secrecy. They are likely to be called "women" - an insult - for performing the roles reserved for women. There are instances where women have been accused of casting spells on their husbands and turning them into "women" because their husbands were seen cleaning or cooking.

Households Headed By Women

The number of households headed by women in Ghana appears to have increased substantially in the past three decades (Ardayfio-Schandorf, 1994:2) ⁸. Between 1960 and 1970, the number of households headed by women increased from 25.7% to 28.6% of all households. The 1984 population census put the national average of households headed by women at 31.9%. A recent study conducted among 304 Ghanaian women found that 52% of them claimed to be the head of their respective households (Ardayfio-Schandorf, 1994:30-47).

Migration - especially migration from the rural to urban areas and migration due to modernization - has increased the number of households headed by women. In some instances, men work in towns or cities far from their wives and as a result cannot live with them. In other cases the partner is abroad. Marriage patterns have also contributed to the number of households headed by women. Some women have absentee husbands and live only with their children. This is often the case for women in polygynous relationships; since the man cannot live with all the women at the same time, some of them are left to care for their own households. The absentee husband occasionally visits his wife or wives and children. In addition, some married women, even those who live with their husbands, are becoming heads of households. These are women who are mainly responsible for the upkeep of their households despite the fact that there are male figures in the households (Ardayfio-

Schandorf, 1992). Other women who are heads of households are widows, divorcees, abandoned wives or single parents.

The income levels of households headed by women are generally low (Ardayfio-Schandorf, 1994; Momsen, 1991:26; United Nations, 1990). At the time of her study in 1988, Ardayfio-Schandorf (1994:41-44) found that the general income levels of the women in her sample were much lower than the national average of 90 Cedis a day, with women who were farmers earning the lowest incomes. Of the women she interviewed 83% mentioned that finances were their major problem. Such women work hard to make enough income to take care of their families. Although Ghana passed the Maintenance of Children Act in 1965, women still find it difficult to take their children's fathers to court for maintenance. Older children help their mothers by becoming petty traders or farm labourers. In times of crisis, women rely on relatives for assistance or child fostering (Ardayfio-Schandorf, 1994:41) ⁹.

In households headed by women, women also perform the functions of both parents. For instance, disciplining children is usually the responsibility of fathers in Ghana, but where there are no male figures, women have to assume the role of the disciplinarian. This can create problems for women because children may refuse to be disciplined by their mothers, who they do not perceive as disciplinarians. It is not easy for women to assume roles traditionally reserved for men. Women who are faced with the challenge of maintaining their households alone thus grapple with numerous responsibilities and expectations. They are exposed to poverty when they do not have adequate livelihoods and their work loads are

heavy. The precariousness of their lives adds strain and tension to their already demanding days.

PRODUCTION: INCOME GENERATING ACTIVITIES OF GHANAIAAN WOMEN

Women have always engaged in productive activities in Ghana (Boserup, 1970; Daddieh, 1989). When barter was practised, women produced a wide variety of crops to feed their families and exchanged the surplus for other items they needed. Of the 246 Ashanti women interviewed in a 1945-46 study only 22, mainly the wives of clerks and teachers, claimed to be non-earners (Fortes, Steel, and Ady, 1948:168, cited in Guyer, 1988:157-158). Boserup (1970:87) also noted that in the late 1960s women accounted for 80% of the labour force in trade, handling both village and urban trade.

Women's productive activity rates were recently estimated at about 90%, with many women self-employed or family workers in agriculture, agro-based industries and trade (Manuh, 1994:62). One important reason for this high rate of productive activity among women is that in most traditional Ghanaian societies women cannot expect to be completely supported by their husbands, especially when they are in polygynous marriages. It is important that they find independent sources of support for themselves and their children (Hagan, 1983; Fapohunda, 1983:33).

Women's labour force participation in the formal sector has increased over the years. With increased opportunity in education more women have been able to secure jobs in the

formal sector (Manuh, 1994:62; Nikoi, 1990:144). Just over half of employed women work in agriculture, animal husbandry, forestry and hunting and almost a quarter are employed as sales workers. Data from the office of the Government Statistician also show that very few women are employed in administrative and managerial work (Nikoi, 1990:143). These data from the mid-1980s indicate that women comprise half of the labour force. They outnumber men in sales work (where they comprise 89% of workers) but they are under-represented in administrative and managerial positions in which they occupy only 9% of the positions. In professional, service and clerical occupations they represent roughly one third of the labour force (Nikoi, 1990:143). For the most part, women's occupational status accounts for their low incomes and this makes it difficult for them to care for their families especially when they are the sole breadwinners.

Most lower-ranked employees in both the public and private sectors are unionized although these unions are not strong. Of the 17 unions that make up the Ghana Trade Union Congress, women constitute about 25% of the membership (Manuh, 1994:62). Only a few women have leadership positions in the unions, even in those that they dominate numerically. Union activities have helped women to achieve minimum employment conditions such as regular hours of work, specific periods of maternity leave with pay ¹⁰ and some degree of social security (Ardayfio-Schandorf, 1994:45; Manuh, 1994:62-63). Although wage rates are low, such employment standards give women regular incomes in

contrast to the situation of the majority of people who work in the informal sector (Manuh, 1994:63).

Despite the insecure working conditions in the informal sector, this sector is key to the survival of a large proportion of women in Ghana (Howie, 1993; Manuh, 1994:63). This sector offers Ghanaian women many opportunities in entrepreneurship. Household-based agricultural production remains a major source of food and income for most of the women who work in the informal sector. These women engage in farming food crops and they process and then market some of their produce. They also trade in local and imported goods. Many of them are engaged in small-scale agro-industry such as handicrafts, pottery, food processing and soap making. They also work as casual labourers on farms, as cement block carriers and workers in quarries.

Women dominate petty trade in Ghana (Sanjek, 1983; Vercrujisse, 1983). In one Ghanaian community, it was found that all girls were trained in trade and start at a very early age (Sanjek, 1983:342). As early as 1960 women made up 84% of traders throughout the country (Cutrufelli, 1983:98) and women's dominance in trade has not diminished. Women trade in all types of items. They dominate in the sale of foodstuffs and fish and they also trade in local and imported goods such as soap and prints.

In describing women traders in Accra, Robertson (1983) identified the strategies that facilitate women's success. Among women's biggest assets are their networks of friends and relatives. Women have managed to dominate petty trade by taking over control of market

stalls and passing them on from relative to relative. They have adopted good marketing techniques and developed their abilities to bargain. They have also demonstrated flexibility, switching to different products when one was no longer profitable (Robertson, 1983:478-480).

Women monopolize the production and marketing of fish (Nukunya, 1992:99-100; Vercrujisse, 1983:169-191). They control the technique of preserving fish, a process which involves collecting and carrying firewood, scaling the fish, arranging them in the oven, firing and unpacking the oven, and packing the smoked fish into baskets for transport to the markets. Women also sell the fish. Hagan (1983:195) stresses the importance of the fish trade women by arguing that apart from the fact that women's marketing activities make money, their control of the fish trade enables them to control their husband's "purse strings" as well¹¹.

Women who sell perishable foods have also adopted methods to ensure success in trading. For example, in a study among women in Winneba, a coastal fishing community in Ghana, Hagan (1983:192-203) found that unlike fishmongers, who were at the mercy of the seasons, other market women who sold crops such as cassava, plantain and yam had evolved a system which enabled them to control fluctuations in supply. They organized themselves into a union to settle conflicts which erupted in the market and to enforce a monopoly in the sale of the foodstuffs they handled. They tried to keep market women from outside the union from bringing in large quantities of foodstuffs to sell in their market, and to ensure a more stable business environment for each member by operating a system which Hagan

(1983:195) calls "the system of circulating monopoly." The women shared market days so that each day belonged to one person or one group of women who had the exclusive right to the food market on that day. They not only eliminated competition through these methods but ensured that each person's foodstuff was sold while it was still fresh.

An important figure in the trading activities of women is the Market Queen Mother. Although the markets are under local administrative control, the market women are also organized and led by Market Queen Mothers. The Market Queen Mother is usually elected democratically by market women to represent retailers who are selling the same goods. There is thus a Market Queen Mother for each of the various items sold in the market such as yams, cassava, tomatoes and pepper (Cutrufelli, 1983:98).

A Market Queen Mother performs several functions. She is responsible for protecting the interests of the particular item that she represents. In the rural areas, where much of the food is produced and distributed at wholesale prices to retailers, the Market Queen Mother is the representative of the supplying and the trading farmers. She helps to find an average price at which such products can be sold. In towns where there is limited space for the traders, the Market Queen Mother ensures that the traders have a fair share of space and supplies.

The Market Queen Mother's role of "regulating" is an important function in times of scarcity (Cutrufelli, 1983:98) since she sets the prices at which items will be sold. Sometimes she acts as a guarantor for retailers who buy from wholesalers on credit. In addition to

protecting the interests of those she represents, securing supplies at reasonable prices and negotiating sale prices, the Market Queen Mother settles disputes between traders belonging to her own group or represents them in agreements or disputes with other market traders or wholesalers (Cutrufelli, 1983:98).

Barriers to Women's Productive Work

Despite the fact that women's productive activities such as agriculture, trading and wage work are the foundations upon which most households survive in Ghana, many factors mitigate against women's productivity. Women are dependent on land, capital, the structure of the labour market for women, the cash rewards of their market work and their own skills and experience (Blanc and Lloyd, 1994:112; Boserup, 1970; Robertson, 1984:10-11). Access to land and credit is limited for most women and critiques of development policies have often focused on the need for improved access in these areas (Ahojja-Patel, 1990:6-19; Mwaka, 1993:46-51).

In the past, women generally had the right to farmland through their husbands or lineages (Okali, 1983; Daddieh, 1989; Nukunya, 1992:98-99). They also acquired land in the form of gifts. Yet women's holdings have differed in terms of crops, acreage and technology from those of their male counterparts (Fapohunda, 1983:52). In a study of land holdings among men and women in some societies in Ghana, it was found that men's cocoa farm holdings were on the whole bigger than those of women. The average sizes of land holdings

for men were nineteen, fourteen and sixteen acres in the Mampong, Konongo, and the Bekwai zones respectively, and ten, nine and eleven for women. In all these areas, women's farms were found to be smaller. Men who were over 45 years of age controlled over half of the acreage in Mampong and Bekwai and two thirds in Konongo. Men over 65 owned a quarter, while women over 65 owned only one twentieth of the land. Thus although there are fewer men than women in the agricultural sector, the men were not only more likely to own farms, but their farms were also on average larger. Men controlled two acres for every acre controlled by women, and their control of land was disproportionate to their numbers (Oppong, Okali and Houghton, 1975:73) ¹² .

Crehen (1984:55, cited by Daddieh, 1989:168-169) argues that women's control of land has remained tenuous even in matrilineal societies. The lineage head or the chief, who is usually a man, is the custodian of the land. He allocates the land to "responsible adults" (typically, married males) who clear the land and either farm with the women or leave the women to farm themselves. Most recently, the commercialization of agriculture, the expansion of cash cropping, rapid population growth and increased competition for land have all helped to create land shortages and limit women's access to land (Norton, 1988 cited in Hood et al., 1992:146-47). Most women are thus left with small and scattered land holdings for their farming activities (Date-Bah, 1984).

Women's access to labour has also been limited. Even when they own their own farms, women often assist their relatives and husbands on their farms. Yet women are less

likely to receive assistance from family members even when their children are very young and despite their heavy involvement in the provision of food for the household (Oppong, Okali and Houghton, 1975:73). Among the Kusasi of the northeastern part of Ghana, men can demand their wives' labour though women do not use their husbands' labour in the same way (Abu, 1994:196; Whitehead, 1994:39). Thus, women may not even control their own labour, let alone the labour of their children or other members of their households. This makes it especially difficult for women to generate income.

Credit has not been readily accessible to most women (Nikoi, 1990:142-165; Hood et al., 1992:147). Ardayfio (1985) found that among Ghanaian urban women, the majority of wholesalers obtained their capital from their own personal savings. However, few Ghanaian women can accumulate sufficient capital as their income is derived from the sale of their own produce and the net gain from this source is usually quite small. Another means by which women obtain capital is the traditional rotating savings credit associations. Seldom, however, can women afford to contribute their share of the money to these capital accumulating associations. Formal credit facilities such as banks are mainly interested in large-scale farmers, cash crop farmers and businesspeople, most of whom are men. As small-scale and food crop farmers, women are thus denied access to credit. Because they lack credit, women are often forced to turn to money lenders whose interests rates can be as high as 50% (Hood et al., 1992:147; Nikoi, 1990:142-165; Roncoli, 1985).

Illiteracy and lack of managerial and technical skills and information have also hindered women's productive activities. It is estimated that 45.5% of male workers and 64.3% of female workers are illiterate (Manuh, 1994:63). In 1992 the general adult literacy rate was 58%; 70% for men and 51% for women (UNICEF, 1993) ¹³. Women's low educational attainments have hindered them from occupying professional positions in the formal labour force. Illiteracy and male-oriented government extension service policies have also prevented women from benefitting from up-to-date information on issues such as new farming methods (Date-Bah, 1984; Roncoli, 1985). Many women farmers are bypassed by extension services and are thus not abreast of the new information and technology available for the improvement of their work activities ¹⁴. They are thus forced to depend on their own efforts and resourcefulness for success in their business activities. The development of appropriate technology has also neglected those technologies which would be of most help to women in their day-to-day work (Barrett and Browne, 1993).

Women's control over the income or products generated by their labour is also limited, despite the fact that Ghanaian customary law supports their right to work and recognizes their exclusive right to separate property (Abu, 1983; Oppong, 1983; Sanjek, 1983). Although in a legal sense it appears that women enjoy a high level of autonomy, in practice their use of their income is restricted. While men often have the liberty to use their incomes in a variety of ways and on personal items, women are constrained by "cultural

values associated with motherhood" (Whitehead, 1994:39); that is, women spend almost all that they earn to provide for their households.

Lack of access to childcare is another barrier to women's employment. Many women lack institutional daycare facilities and have to rely on extended kinship networks, paid household help and child fostering (Ardayfio-Schandorf, 1994: Blanc and Lloyd, 1994:113). Although these sources of childcare have been very beneficial to many women, they are not necessarily available to all. Women in urban areas find it more difficult to obtain these forms of childcare and are thus quite dependent on institutional daycare facilities which are either expensive or far from their homes.

Ghanaian women can be found in almost all sectors of the economy and they continue to dominate in trade. Yet, they face a number of constraints. They have limited access to land, credit, labour and daycare facilities. Male-centred government policies do not provide women with the tools and information they need. Finally, women's reproductive roles, their positions in the household, and the sexual division of labour all constrain women's productive activities.

THE STRUCTURAL ADJUSTMENT PROGRAM

International and national policies have had differential impacts on the lives of women and men in Ghana. Ghana has initiated many development programs over the years and like many other developing countries, has claimed to emphasize gender-neutral

economic growth. It has been argued that an increase in the Gross National Product (GNP) will "trickle down" the income hierarchy to a country's poorest groups and thus benefit all people (Kabeer, 1992:102). In practice, however, economic growth has frequently been accompanied by increased unemployment and poverty, and those most severely affected are women and children. A case in point is the recent Structural Adjustment Program (SAP) adopted by many developing countries including Ghana.

In their efforts to recover the debts of developing countries and resolve the chronic balance-of-payments crisis, major donor agencies such as the International Monetary Fund (IMF) and the World Bank implemented the SAP in 1979 (Spaar, 1994:2). Under SAP, in order for "debtor countries" or developing countries to qualify for new loans the international banks required them to become more free market oriented. Governments are required to reduce their spending and remove subsidies and regulations on products and services (Kabeer, 1992:103; Spaar, 1994:1-2). Under the Ghanaian Economic Recovery Program/SAP, measures have been taken to reduce government expenditures, decrease the role of the state in economic activity, increase the competitiveness of the export sector and liberalize trade. The government also placed a limit on credit expansion. Budgets have been cut and wages have been frozen. There have also been exchange rate adjustments and new trade policies (Hood et al., 1992; Manuh, 1994:66).

The Ghanaian Economic Recovery Program has increased employment in the mining, timber logging, transport and communication sectors in the country, sectors which do not

traditionally employ women (Manuh, 1994:67). Women are prohibited from working underground in mines, and while they are employed as clerical staff in the transport and communications sectors, they are not hired as drivers or road construction or telecommunications workers. For the most part, then, women are excluded from the jobs that have been created by SAP. The only sector in which women are likely to be employed as family workers is cocoa farming which has flourished in response to producer price increases for export crops (Manuh, 1994:67). The overall effect of SAP on women appears to have been negative.

One main aim of SAP has been to reduce the number of people in the civil service. Between 1987 and 1992, almost 60,000 workers were laid off from the civil service (Daily Graphic, 15th December, 1992 in Ardayfio-Schandorf, 1994:2). Women have been vulnerable in many of these retrenchment exercises as a result of their low educational levels and their concentration in many of the sectors targeted for redeployment (Manuh, 1994:73). The civil service redeployment schedules, for example, listed labourers, cleaners, drivers, cooks, porters, sweepers, messengers and security personnel, clerical officers, secretarial personnel and store officers, several of which are occupations in which women are disproportionately represented. Budget cuts in the Ghana Education Service and Ministry of Health, have led to job losses for women employed as cooks and caterers in educational institutions and departmental canteens which have been closed (Manuh, 1994: 68). In theory

laid off workers were supposed to move into other sectors of the economy; in reality the process had meant unemployment for most workers who were laid off.

Cutbacks in public expenditures have also worsened the status of women since women are the main consumers of health, education and other welfare services. It is women who will shoulder the heaviest burden of the cutbacks in services which result from SAP. The budgets for education and health, for instance, are continually being cut. Between 1986 and 1992, the percentages of central government expenditure allocated to health and education were 9% and 26% respectively. By 1993 these allocations had decreased to 7% for health and 22% for education (UNICEF, 1995 and 1996). Thus structural adjustment policy measures have reduced women's chances of employment and their opportunities to retain jobs and at the same time increased the price of social services such as health care, water, electricity and education.

The informal sector of the economy, where women abound, has also been affected by SAP. SAP has worsened the already insecure conditions in this sector. The increased competition and higher prices resulting from SAP have not been accompanied by higher purchasing power, given the general low level of incomes. The result has been that business has been very slow, making it more difficult for women to earn an adequate income.

The family is the hardest hit in times of high unemployment. The SAP has led to the dislocation of the family which has resulted in "role shifts and role conflicts" (Ardayfio-Schandorf, 1994:2). The responsibilities of women whose husbands have lost their jobs as

a result of the SAP have increased. An increasing number of women have become financially responsible for the household in addition to playing their traditional domestic roles. The present economic situation has forced women to adopt new strategies for survival. These strategies have been called "the invisible adjustment," a term which highlights how women are making the Structural Adjustment Program socially possible by increasing their economic activities and working even harder (Momsen, 1991:97). Women's existence is more precarious as they juggle even more income-earning activities and assume ever more responsibility for the care of family members who are ill.

The gender bias that appears in state policies has been explained in terms of the lack of representation of women in policy making positions. Women in many developing countries are excluded from participation in state politics as their primary roles are defined exclusively in terms of the family. As Parpart and Staudt (1989) have pointed out, women represent half or more of the electorally franchised population in the developing world and thus half of the recruitment pool for political office. Yet during the mid-1980s women represented only 6% of members of national legislatures. Also, women generally constitute less than 2% of national cabinet or equivalent positions. Since the vast majority of public officials are men, male-centred ideologies, conventional wisdom and personal material realities are brought to bear on decision-making processes (Charlton, 1989:13). It is in this connection that state policies and actions provide a clear link to gender concerns.

Afshar (1987) argued that many governments appear to have strong ideological fears about women who are not confined to the domestic sphere. Women have been perceived as agents of "corruption" in Ghana (Robertson, 1984), Nigeria (Roberts, 1987) and Zimbabwe (Jacobs and Howard, 1987). In the failure of economic policies, Ghanaian women were accused of being responsible for economic hardships because of their visible role in trade. One of the more extreme acts in the past illustrates the way women traders can be persecuted for the country's economic problems. One of the markets in Accra called "Makola Number One" was demolished by soldiers who seized power from the Acheampong regime in 1979. The rationale behind the demolition, as the perpetrators themselves explained, was to "teach Ghanaian women to stop being wicked" (Robertson, 1984:244). In the same period some of the market women were also physically punished and forced to bear the brunt of public displeasure provoked by shortages of goods (Robertson, 1983:469). These strong culturally-rooted fears can sometimes be seen to have generated policies and laws which oppress women.

Women are frequently harassed by state and municipal authorities. Because they are not well organized, they have little power to fight for better working conditions. In Ghana women are often forced to pay high fees to license their economic activities. Women petty traders are constantly being harassed or beaten by the town and city council workers to force them to pay for market tolls. In the 1980s, for instance, many women, accused of engaging in "Kalabule"¹⁵ were beaten and disgraced. In a coup d'etat the military justified their actions

by arguing that living conditions in Ghana were becoming difficult, even unbearable. The country's problems were blamed entirely on women traders. This culminated in the demolition of another of the main markets, "Makola Number 2," in which women traded.

Furthermore, gender ideologies can be observed in state policies where little or nothing is done to question men's control over women. In addition to making laws which discriminate against women, the state fails to protect women against violence, such as rape or domestic battery, or sexual harassment at work places. The subject of violence against women is seldom discussed in Ghana (Ampofo, 1993; Ofei-Aboagye, 1994). When attempts are made to address particular instances of violence against women, factors such as different definitions of violence, different laws, the attitudes of law enforcement agents (especially regarding domestic violence), and social norms make application difficult and make women more vulnerable (Ampofo, 1993:103).

Efforts have been made by the state to protect women against certain widowhood rites and to provide some security for widows through laws such as the Interstate Succession Law. But the reality is that the majority of women in Ghana are not aware of the existence of such laws. Even where they are aware, many women are not able to exercise their rights because they fear social sanctions. Insisting on one's legal rights goes against tradition, and this can result in a woman being rebuked or isolated in the community. Traditional laws and customs are often stronger than civil laws in the day-to-day lives of women, so the existence of state laws alone does not guarantee their enforcement.

In examining policies and planning by governments and international aid and development agencies, it becomes obvious how most public policies discriminate against women. The initiative of women in the planning and the implementation of policies is almost absent. As a result, women have invariably borne the adverse effects of policies and laws. The SAP being implemented by the Ghanaian government is a clear example of a policy which has had significant negative impact on women's lives.

WOMEN'S HEALTH AND WELL-BEING IN GHANA

As I noted in Chapter Two, there are few data describing in detail the health situation of women in Ghana. The data which are available focus mainly on women's biological reproductive health. I begin this section on women's health and well-being with a table which incorporates general measures of the health and well-being of Ghanaian women. Table 3-1 gives us an impression of women's health status and their quality of life.

The table shows that Ghanaian women's life expectancy at birth is 61 years. This is much shorter than that of women in the developed countries who can expect to live for about 75 years (United Nations, 1991:55). One reason for Ghanaian women's shorter life expectancy is the high infant and child mortality rates. As the table indicates, the infant mortality rate in Ghana is 76 per 1,000 live births and the child mortality rate is as high as 131 per 1,000 live births. Women's life expectancy is also diminished by the high rate of maternal mortality. Maternal mortality rates ¹⁶ in Ghana remained very high at 1000 per

Table 3-1: Women's Health and Well-Being

Indicators		Males	Females	Females as % of Males	Urban	Rural	Total
Life Expectancy at birth (yrs) [1994]			61 ¹	107			56
Infant Mortality rate per 1,000 live births (under 1 yr) [1994]							76
Under 5 yrs Mortality rate per 1,000 live births [1994]							131
Maternal mortality rate per 100,000 [1980-92]			390				
Percentage of births attended by trained medical personnel [1993-94]							59
Total fertility rate [1994]							5.8
Contraceptive prevalence (15-49 yrs) [1980-94]			20				
Percentage of children [1986-1994] who are	Exclusively breastfed (0-3 mos)						8
	Breastfed with complementary food (6-9 mos)						36
	Still breastfeeding (20-23 months)						53
Percentage of children under five [1980-1994] who are suffering from underweight	Moderate and severe						27
	Severe						8

(cont'd)

Table 3-1: Women's Health and Well-Being

Indicators	Males	Females	Females as % of Males	Urban	Rural	Total
Daily per capita calorie supply as percentage of requirements [1988-90]						93
Percentage of share of total household consumption [1980-85] all food						50
Percentage of population with adequate sanitation [1990-95]				53	36	42
Percentage of population with access to safe water [1990-95]				70	49	56
Percentage of population with access to health services [1985-95], [1993-94]				92	45	60
Primary school enrolment ratio (gross) [1986-93]	80	67				74
Secondary school enrolment ratio (gross) percentage [1986-93]	48	29				
Total adult literacy rate, 15 years and older (percentage) [1990]	71	46	65			58

¹ The World Bank World Development Report, 1985. Compiled from: *The State of the World's Children*, UNICEF, 1996, Oxford University Press, New York, NY, p. 79-109.

100,000 live births between 1980 and 1990 (UNICEF, 1991:114). Table 3-1 shows, however, that the rate has fallen dramatically since 1991 to about 390 per 100,000 live births. Maternal mortality in Ghana is still high relative to the rate in developed countries which is about 11 per 100,000 live births (Boerma, 1987:551).

Information on the causes of maternal mortality and morbidity, although biomedical in nature, sheds some light on the immediate causes of women's deaths. The leading direct cause of death among pregnant women in 1989 was hemorrhage, of which post-partum haemorrhage was the main factor. This was followed by infection, particularly septicemia. Hypertension came next with eclampsia the most frequent presentation, followed by ruptured uterus. Postpartum hemorrhage, septicemia and eclampsia, which together accounted for 42% of the deaths of pregnant women, are all preventable. In this connection it is noteworthy that only 59% of births in Ghana are attended by trained health personnel. According to sources from UNICEF, by 1994 only 59% of births in Ghana were attended by trained professionals (UNICEF, 1996). The remaining births took place without the assistance of trained health personnel. Deliveries are often performed by relatives, friends and neighbours, at the woman's home. A 1988 health survey in Ghana indicated that in rural areas about 31% of deliveries were done by relatives and people other than trained health care professionals; in urban areas, the figure was 12% (Ghana Demographic and Health Survey, 1989:69). Kpando, the site of my research, is in the Volta region, and the same survey found that the Volta region had the highest number of deliveries by people who were not trained health care

professionals. In the Volta Region about 42% of deliveries were done by relatives and others with no special training. Women risk dying in the process of giving birth as people without specialised health training are unable to deal with complications that may arise during the birth of a child. The risks associated with childbirth increase when pregnant women are already weakened by several previous deliveries and by the hard work they do every day. The inadequacy of maternal health facilities partly explains the high level of maternal mortality.

When we add deaths caused by induced abortions to maternal deaths the picture of women's reproductive health becomes even grimmer. As is the case in many developing countries, abortion is illegal in Ghana. Women who want to terminate unwanted pregnancies are forced either to attempt abortions on their own or to seek help from untrained personnel under dangerous conditions with little after care (Raikes, 1989:449; Santow, 1995:150). Although the documentation on mortality from unsafe abortions in the developing countries is inadequate one can expect the figures to be very high.

In 1994 the fertility rate ¹⁷ among women in Ghana was 5.8. With fertility rates so high, women are exposed to the risks associated with pregnancy several times during their reproductive years (Santow, 1995:150). Women have little control over their fertility. Although factors like education and urbanization are influencing fertility, the social factors accounting for high fertility are still very powerful. Giving birth to children is considered to be a woman's "proper role" and it is thus incumbent upon a woman to demonstrate that she

is fertile as this enhances her status and social esteem (Adepoju, 1994:23; Awusabo-Asare, Anarfi and Agyeman, 1993:70). Women who seem to be deviating from their roles as mothers are pressured into complying (Ardayfio-Schandorf, 1994; Adepoju, 1994; Dinan, 1983:344). Compliance is enforced through rebuke, gossip, open insults, or shunning by women who are mothers. The high infant mortality rate is another reason Ghanaian women give birth to many children. Women feel that having many children increases the likelihood that some of them will survive. Other practical considerations help explain the high fertility rates of women in Ghana. From an economic point of view, more children means more free labour on the farm or for other economic activities (Benneh, 1994:5-12). When children become economically independent they serve as a source of social security for their aging parents by supporting them physically and financially (Benneh, 1994:6; Ardayfio-Schandorf, 1994:39). The more children one has, the greater the chances that one will have people to rely on in old age. Other factors which contribute to the high fertility rate in Ghana include the desire to have a child of a particular sex (mainly a son to carry on the family name), the relatively early age at which women marry ¹⁸, and competitions among co-wives over the number of children they are capable of producing. These social and economic factors explain in part the low contraceptive use among women. Table 3-1 indicates that in 1994, only 20% of married women between the ages of 15 and 49 were using contraception.

With many children the demands of childcare are significant. Childcare is a continuous and demanding activity. Among the demands of caring for children is that they

have to be bathed, fed and comforted several times every day. To ensure that children are safe and unharmed, they would have to be constantly supervised. With many children, these demanding and tedious activities associated with childcare are performed many more times and for longer periods of time. Another aspect of having many children which may have an impact on women's health is frequent and prolonged breastfeeding. Mothers in Ghana breastfeed for long periods of time. As Table 3-1 indicates, 8% of mothers exclusively breastfed their babies aged zero to three months, 36% breastfed their babies aged six to nine months in combination with other foods while 53% of mothers continue to breastfeed children who were more than one year old.

Women's heavy childcare demands are combined with the need to care for elderly and other members of the household, heavy household responsibilities and multiple work activities. As we have seen from earlier discussions, women spend several hours doing domestic work and engage in multiple income-generating activities every day. This complex interplay of various forms of women's work both in the household and outside it, in all likelihood causes and exacerbates health problems for women.

In their capacity as wives, mothers and carers for dependent kin, women are the main providers of health care in Ghana. They engage in preventive medicine by working hard to maintain hygienic conditions and to provide their families with nutritious diets (Brydon and Chant, 1989:190; Rathgeber and Vlassoff, 1993). Women are often the first to detect early symptoms of illnesses in children, husbands, and other dependants and they frequently take

the initial steps to prevent illnesses from developing. This role exposes women to communicable diseases. When children need to be taken to health centres or hospitals for treatment it is women who take the initiative. When a man is in hospital, his wife or other female relatives are responsible for supplementing nursing care for him. The cost in terms of the strains and stresses on women of anticipating and managing the family's health needs is difficult to measure. Women's roles as promoters and providers of health clearly contribute to their responsibilities in the home.

Inadequate nutrition is another dimension of the problem of Ghanaian women's health, and it too is related to household size. A large household can mean insufficient food in quantity and quality for all. This results in poor nutritional status for large households and ultimately poor health. As Ghanaian women are known to cope with household crises such as inadequate food by putting their own needs last, it is common for women to eat less, and less nutritious food, than men. With inadequate food intake women are at risk for anaemia, malnutrition and severe fatigue (Jacobson, 1993:3). Women's nutritional requirements become more important during their pregnancies and lactating periods. Poor nutrition has adverse effects on the health of mothers, unborn children and nursing children. Maternal malnutrition is one of the most important factors contributing to low birthweight babies (Raikes, 1989:449). As table 3-1 shows, between 1990 and 1994, 17% of infants in Ghana were born with low birthweight, and 27% of children under five were moderately to severely underweight (UNICEF, 1996:82). Although the data have not been broken down by gender

in Ghana, we know that young girls who experience malnutrition are not able to develop sturdy bones and it is likely that this makes them vulnerable to complications during childbirth and may even result in their deaths (Santow, 1995:150). A significant percentage of people in urban areas (59%) and rural areas (37%) live below the poverty level. This means that often there is less food than is needed, and as Table 3-1 indicates, the daily per capita calorie supply is only 93% of the requirements for the average Ghanaian, indicating that people in Ghana consume less than the required amount of calories for normal growth.

The quality of women's lives and health is further threatened by poor sanitation. Only 42% of the Ghanaian population has access to adequate sanitation (53% of the urban population and 36% of the rural population). As Table 3-1 shows, only 56% of the total population has access to safe water, and access varies by location. While 70% of those who live in urban areas have safe water, only 49% of those who live in rural areas have access to some form of safe water. It is not surprising then that women's health problems other than maternal health problems are grouped under water-related environmental and sanitation diseases (Ghana Population and Health and Nutrition Survey, 1988:93). Women are exposed to many infectious diseases: malaria, infectious hepatitis, dysentery, hookworm, bilharzia, guinea worm, yaws and sexually transmitted diseases. In considering women's susceptibility to these diseases we need to reflect on the roles women play both at home and outside the home. For instance women may suffer from bilharzia or guinea worm because of their role as the primary providers of water. Most women have to collect water for their households

from sources such as streams and rivers, some of which are contaminated and expose them to water-borne infectious diseases. Furthermore, the nature of women's productive work activities are associated with many other health hazards. For instance women's agricultural work activities expose them to dangers including snake or rodent bites, cuts from old and rusty farm tools, falls from the weight of the heavy loads they carry home from their farms, heat from the sun and cold from the rains.

In addition, a health problem of great concern to Ghanaian women is HIV/AIDS. Almost two-thirds of HIV positive people in Africa live in Sub-Saharan Africa (Okoje, 1994:1239). Recent publications on AIDS have shed light on some of the factors accounting for the spread of the disease. The widespread acceptance of men having multiple partners, the poor economic situation of many women which leads some of them to supplement their incomes with prostitution, and the general lack of knowledge about the use of condoms are all said to contribute to the spread of AIDS (Anarfi, 1993:45-68; Awusabo-Asare, Anarfi and Agyeman, 1993:69-84).

Resources that could improve women's lives - health services and education - are also in short supply. Although a good percentage of the Ghanaian population (60%) are said to have access to health care services, the majority of health facilities are located in urban areas¹⁹. Only 45% of the rural population have access to health care services, and the majority of rural dwellers in Ghana are women. As health facilities are not well developed especially in rural areas women travel great distances and wait long hours in lineups for

treatment at hospitals and health centres. Long waits in hospitals have eroded women's already limited time for seeking medical attention for their children and themselves. The increasing cost of health services and cutbacks in health provision have reduced medical consultations and increased self-medication with its attendant risks (Ardayfio-Schandorf, 1994:45). In terms of education, women are at a disadvantage compared to men. While 80% of males get the chance to enrol in primary school, only 67% of females are able to do so. The secondary school enrolment picture is similar. While 48% of males continue their education in secondary schools only 29% of females are able to do so.

The factors that determine women's health status are interrelated. Poor and inadequate diets and frequent childbirth put women at risk for many health problems. Women's roles in biological reproduction, social reproduction and production all appear to have implications for their health. However, the literature on the relationships between, women's lives and women's health is sparse. We need considerably more information and analysis if we are to unravel or understand the nature and the causes of women's health problems.

SUMMARY AND CONCLUSION

In outlining various aspects of Ghanaian women's day-to-day lives, this chapter has established a context for subsequent chapters of this study. I have discussed the main social structures influencing women's life chances and described how women try to respond to the effects of these structures. I identified cultural perceptions of Ghanaian women and

considered how these images and expectations influence how women live their lives in Ghanaian society. The chapter presented a picture of Ghanaian women's lives and roles both within and outside the household and described women's heavy work loads. It also showed how women's lives are affected by the policies and programs implemented by government. In this connection I stressed the stifling effects of certain government policies and programs, in particular the SAP, on the well-being of women in Ghana. Although there has been little assessment of the gender impact of this program, there are clear indications that SAP has had adverse effects on the most vulnerable in society, that is, women and their children.

The discussion in this chapter also points to the ways in which the structures that impinge on Ghanaian women's lives are intertwined. As the chapter notes, women, who are both producers and consumers of wealth, health, and other social facilities are being forced to shoulder the heaviest burden of poverty and stress. The heavy and increasing burdens on women and the lack of adequate health care and other facilities is likely to increase morbidity and mortality among women in Ghana.

This discussion provides a broad context for the analysis of the interviews in subsequent chapters. The chapter alerts us to the importance of the features that influence the lives of Ghanaian women. It highlights the structural constraints under which women live and work every day in Ghana. It also describes the general health situation of women in Ghana stressing the health hazards they face. The specific focus of this study is on women in Kpando, a community in the Volta Region of Ghana in West Africa. In the chapters that

follow we shall see how Kpando women try to establish a link between women's health status and the conditions of their day-to-day lives. While their accounts reinforce most of the themes we have already described generally in this chapter, we will find that women also reveal details of their lives that may be somewhat unique to them and specific to the Kpando environment. Overall, however, women's accounts of their health will help us understand the various levels at which health is socially produced in Ghana. In the next chapter I describe how I conducted my research and the methods I used to collect the data.

NOTES

1. I use the expression "Ghanaian societies" to indicate that Ghanaians are not a homogeneous unit. Ghana is made up of various ethnic groups and although there are similarities in the ways people behave and think in these groups there are also significant differences.
2. Highlife is a blend of traditional Akan rhythms and melodies with European musical elements. It encompasses a variety of artistic expressions such as music, dancing, singing, story-telling and theatre. It originated at the end of the nineteenth century, but the exact source is not known. It began at the coast and has spread to all parts of the country. The themes of the songs are predominantly urban life and social mobility. The term "highlife" reflects these themes in that it suggests the life of the (Ghanaian) "high society" in towns (Asante-Darko and Van Der Geest, 1983:244).
3. During a conference in Addis Ababa in 1990 on Traditional Practices Affecting the Health of Women and Children, it was decided that the term "Female Genital Mutilation" (FGM) should be adopted since "female circumcision" or "excision" was misleading.
4. For the purpose of this research the household is defined as people who share domestic functions and activities - a group of people who "eat out of the same pot" (Mackintosh, 1979) or who "share the same pot" (Robertson, 1984a). This definition is appropriate in the Ghanaian situation where members of a household may not necessarily share a residential unit. They may live in different places yet depend on a particular place of residence for their sustenance.
5. Wood fuel and hydroelectric power are the most important energy sources in Ghana. In 1987 wood fuel constituted 86% of total energy consumption in households. Wood fuel alone accounted for 92% while hydroelectric power comprised 8% of the domestic energy output (Ghana Government, Ministry of Fuel and Power, 1988).
6. "Solom" or "pito" is a local beer brewed with millet. "Akpateshi" is gin, usually brewed with palm wine, sugar cane or mangoes. The process of brewing requires the use of a lot of water and fuel.
7. "Banku", "amawoe" or "akple" is a Ghanaian staple food prepared with corn flour. It is prepared as a thick paste and eaten with sauce or different types of soup.
8. A head of a household is defined here as "the one who is generally responsible for the upkeep and maintenance of the household on a day-to-day basis, and who has the power

to make major decisions within it" (Ardayfio-Schandorf, 1994:34).

9. **Child fostering is a situation where a child is taken from his or her parents and trained and taken care of by other members of the family. This is a common practice in Ghana because children are regarded as belonging to the whole extended family and not only to the biological parents.**
10. **The Labour Decree (1967) National Liberation Council Decree 157 provides maternity leave for women for up to 6 weeks before the birth of a baby and up to 6 weeks after the baby is born. This leave can be extended if there are problems with the birth or if it is a multiple birth. The woman's job is protected during this period and she receives full pay for three months. When the mother returns to work, she is allowed one hour a day for nursing.**
11. **A fisherman usually gives his catch to his wife, wives or other relatives for processing and sale. It is usually after the sale of the fish that the fishermen are paid.**
12. **Okali (1983:173) points to the fact that it is sometimes difficult to measure the acreage of women's farms because the land demarcations are sometimes vague.**
13. **The "Adult Literacy Rate" is defined as percentage of persons aged 15 and over who can read and write.**
14. **Extension services are normally geared towards the more well established and larger farmers who are most often males.**
15. **"Kalabule" was a term used in Ghana in the late 1970s and 80s to describe trade malpractice and extreme forms of corruption.**
16. **"Maternal mortality rate" is the "annual number of deaths of women from pregnancy-related causes per 100,000 live births" (UNICEF, 1996:102).**
17. **"Total Fertility Rate" is defined as "the number of children that would be born per woman, if she were to live to the end of her child-bearing years and bear children at each age in accordance with prevailing age-specific fertility rates (UNICEF, 1996:102).**
18. **In Ghana the average age at which women marry is 18 (Ghana Statistical Service 1989a).**
19. **"Access to health services" is defined as the "percentage of the population that can reach appropriate local health services by the local means of transport in no more than one hour" (UNICEF, 1996:102).**

CHAPTER 4: METHODOLOGY AND FIELD EXPERIENCE

THE STUDY AREA

This research was conducted in Kpando, a town in the Volta region of Ghana, West Africa from November 1994 to March 1995. Kpando is one of the district headquarters in the Volta region. The district has a population of approximately 35,600: 18,000 males and 17,600 females (Population Census of Ghana, 1984: Volta Region: 81). The town is located inland in the southwestern part of the Volta Region. Its western side is flanked by the Togo ranges and its eastern bank by the Volta Lake. The research was concentrated in the Kpando area which is made up of several villages: Aziave, Gabi, Tsakpe, Aloi, Dzogbati, Gadjia, Fesi, Bame, Djigbe, Djewe, Agbenoxoe and Ekple. The villages of Aziave, Gabi, Tsakpe, Aloi and Djigbe, are large units and they merge into each other to form a string of villages called the central Kpando area. The rest of the villages, Dzogbati, Gadjia, Djewe, Agbenoxoe, Bame, Fesi and Ekple are smaller and scattered about. The central Kpando area and the scattered villages make up what is called the Kpando traditional area. The Kpando locality has a population of about 15,700: 8,400 males and 7,300 females. (1984 Population Census Report: Volta Region: 81).

Since Kpando is the district centre, it acts as the district administrative capital. The administrative machinery is made up of the District Chief Executive (presently a woman) who is politically appointed, the District Co-ordinating Director, the head of the civil service and the district officers for various departments including Information, Health, Social Welfare, Agriculture and Community Development. Kpando is also the location of the district circuit court and prison.

Despite the bureaucratic administrative machinery, traditional chiefs, queen mothers¹ and sub-chiefs continue to play important administrative roles in the community. For instance, the chiefs and queen mothers sit on various committees which attend to the welfare of the community. Chiefs and queen mothers also work hand in hand with state law enforcement agents such as the police and town council agents.² From their positions in the formal administration and in their traditional roles, chiefs and queen mothers contribute to the dissemination of information and the mediation of domestic as well as inter-clan disputes.³

In terms of infrastructure, Kpando has some modern facilities such as pipe born-water, electricity, a post office, two banks, a hospital, a health centre, a market and secondary schools. However, Kpando lacks a good communication network. The few roads linking Kpando to outlying areas are narrow and ridden with pot-holes. In the dry season, some of the roads are dusty. In the wet season, they are muddy and sticky and sometimes impassable by vehicles. Kpando lacks a telephone network as well. Very serious sanitation problems also

face the town. Although there are no data to indicate the number of toilets in the town, I observed that many houses do not have toilet facilities. People often walk long distances to use public latrines which are few and often in deplorable condition. Lack of potable water is a major problem facing the town. People walk very long distances and stand in line for several hours to buy water. To avoid such situations, many people depend on wells, rivers and streams for their water, though these are unsafe and often make people ill.

Kpando has two secondary schools and one technical institution. There are numerous primary schools as well as new "Junior Secondary Schools". There are also many private vocational schools or apprenticeship shops where young women and men learn skills such as seamstressing or tailoring, hairdressing, cooking and mechanics. Most of the women who learn these skills have completed Form 4⁴ or have dropped out of school for reasons such as pregnancy or lack of money. They often become apprentices to seamstresses and hairdressers, or traders. In situations where they do not have enough money of their own to begin a trade, these young women accumulate capital by selling goods for Market Queen Mothers⁵ who pay them on a commission basis. Kpando is a trading centre for numerous villages and towns. Several factors account for its emergence as a trading centre. The Germans who originally colonized parts of the Volta region made Kpando one of their main commercial and administrative centres and this led to the construction of certain modern facilities (Dzakpasu, 1993:12-13). Also, the construction of the Akosombo dam for hydroelectric power resulted in the movement of the Volta river closer to Kpando and

promoted the development of the fishing and commercial village of Kpando-Torkor. Kpando-Tokor village is about 4 kilometres from Kpando and has a population of 1,537 (Population Census of Ghana, 1984). The inhabitants were evacuated from the Volta basin during the construction of the dam and now engage in fishing and irrigation farming at the banks of the Volta river (Dzakpasu, 1993:13). These factors have contributed to Kpando becoming a convenient stop for travellers and traders, especially fishmongers.

Despite the proximity of the Volta river, the people of Kpando have traditionally been subsistence and commercial farmers (Dzakpasu, 1993). The main crops cultivated are food crops such as maize, cassava, yam and vegetables. Kpando is also noted for its potters, who produce cooking pots, bowls and other items of practical and aesthetic value. Women perform important functions in the economic sphere in Kpando. They are the main producers of vegetables such as tomatoes, pepper and leaf vegetables. They are the sole processors and preservers of fish. They also specialize in moulding and making clay pots and bowls. Kpando women are known to be very powerful middle-women in the sale of fish and other food items that come into the market. Finally, women control numerous local restaurants popularly known as "chop bars" and drinking bars.

Kpando can be described as predominantly Christian. Catholic, Evangelical Presbyterian, Anglican, Pentecostal and Apostolic churches are represented. However, as is the case in all Ghanaian communities, most people in Kpando still adhere to indigenous traditions. Beliefs in traditional gods, ancestors and such malevolent forces as witchcraft are

strong. The influence of these beliefs in the lives of the people is reflected in various rites and rituals such as child naming, puberty rites ("gbortoworwor"), marriage, festivals and ceremonies related to death (Owusu, 1994).⁶

Many houses are occupied by extended families with two to three generations living together. In a typical extended family house, parents live with their children and their children's partners, and their children's children, and sometimes their partners. In the central Kpando area itself, because of migration, family houses often have vacant rooms or apartments. Some people rent their spare rooms or apartments to other people who are not members of their families.

Extended family houses are normally very large. Most of them are rectangular in shape. Others, especially those built with mud are circular. Many of the houses are surrounded by square or circular walls which serve as a protective fence. Often an open area in front of each house serves as a common compound for the whole house. There is usually at least one shady tree, such as a mango tree, standing in the middle of the compound. This serves as a resting place for members of the house especially in the afternoons. A shed in the compound often functions as the kitchen. Under the shed are one or two switch stoves and sometimes a coal pot. Firewood is usually stored at the extreme end of the kitchen or of the compound. If the members of the household do not cook together, there may be several sheds on the compound for each group that cooks together in the household. For instance, a smaller group might include an individual with his/her partner and children and his/her unmarried

brother or sister. The houses do not have toilets and people therefore rely on public toilets or use the bushes in the immediate neighbourhood. Most houses have bath places located at the back of the compound. The bath houses are often built with corrugated iron sheets, or fences made of dry palm branches. Some bath houses are built with cement walls or cement blocks arranged on top of each other. The floor of the bath houses are normally covered with pebbles. A bigger rock serves as a seat for those who want to sit down while bathing. Most bath houses do not have doors and the entrances are covered with cloth when in use. As bath houses are usually not covered and normally have walls shorter than the chest of most women, those bathing during the day time expose the area from their breasts upwards.

It is within this setting that the research was conducted. The following sections outline my methods of data collection, the composition of the sample and the nature of the interviews.

INTERVIEWS

Several methods were utilized for data collection. These included interviews (with a written interview guide), participant observation, focus group discussions and documentary sources. A snowball sampling method was adopted to contact potential interviewees. One problem with this sampling method is the likelihood of a bias being introduced into the research because interviewees tend to identify people who are similar to themselves

(Tepperman and Richardson, 1991:49). Tepperman and Richardson (1991:49) have noted the value of starting "several snowballs rolling" and using a "quota system" to offset some of this bias. Thus, in order to ensure that respondents were not concentrated in just one area or among one group of women with similar characteristics, I conducted interviews in different neighbourhoods and villages. I also interviewed women of different ages, marital statuses, household compositions, educational levels and occupations.

Limiting the number of interviews conducted in one neighbourhood was sometimes difficult because of the living arrangements of women in Kpando. Women continue to live in their extended family households or move to join those of their husbands. Thus, I encountered situations where too many women in the same household expressed interest in being interviewed. I sometimes had to turn down women with tactful explanations. In such instances I would give a token gift to thank them for expressing their interest in the interview.

Most of the interviews were tape recorded and subsequently transcribed. The full interview guide can be found in Appendix A. The length of the interviews varied from thirty minutes to about three hours. In an attempt to allow women's own concerns to emerge, different approaches were adopted to encourage women to talk during interviews. I did not rigidly follow the interview guide, but rather approached each interview with flexibility so that the interview situation determined the approach adopted. In some cases interviewees started to talk without any prompts and I delayed questions until later in the interview when

I could explore issues in my interview guide without imposing my own concerns at the outset. Other interviewees encouraged me to start with questions. With time however, many of them took control over the flow or the course of the interviews. In essence, I made no attempt to religiously follow the interview guide, and this allowed women to have more control over the interview situation. With this flexibility, I sought to achieve a balance between the women's concerns and my own particular interests.

Almost all the interviews were conducted in the local language (Ewe) and then translated into English for transcription. The translation was difficult sometimes due to the fact that there are no English equivalents for some Ewe expressions. In some situations I edited the conversations while trying to maintain the original meaning. In other instances I maintained some Ewe expressions and found words to convey their meaning in English. In the passages used in this thesis, the Ewe words are in quotes and the English words in brackets.

After each interview I noted the main themes women raised and, as the research proceeded, I could see the themes which were recurring as well as new ones that were emerging. This allowed me to probe for more details on issues I wished to clarify. In some instances, I revisited respondents to talk further about issues they had mentioned. I was able to validate the themes through observation within the community, focus group discussions and informal conversations with women. On my return to Canada, in transcribing the interviews, I was able to trace the details of themes and tabulate responses. These were cross

checked with my earlier categorization in the field, my field notes and records of the focus groups.

The Sample

I interviewed 75 adult women. As Table 4-1 indicates, their ages ranged from 20 to 80 years. Many women were in their childbearing years. The two women who replied “don't know” were both roughly 60 years of age.

TABLE 4-1: AGES OF WOMEN

AGE IN YEARS	NUMBER	PERCENTAGE
20-29	11	15
30-39	22	30
40-49	20	27
50-59	13	17
60-80	7	9
Don't know	2	3
TOTAL	75	100

TABLE 4-2: MARITAL STATUS

MARITAL STATUS	NUMBER	PERCENTAGE
Married/ Cohabiting	38	51
Absentee husbands	9	12
Widowed	9	12
Divorced/ Separated	6	8
Single	13	17
TOTAL	75	100

As can be seen in Table 4-2, most of the women interviewed were married. There were, however, many women with absentee husbands. This was due to the polygynous marriages in which husbands lived with their co-wives and visited only from time to time. The husbands of some of the women had also moved elsewhere for job purposes or travelled overseas. The last time one interviewee saw her husband, for instance, was seven years ago. A number of women were also widowed, separated or divorced. Several women (17%) said they were single. Thus, almost half of the women interviewed either lived alone or had absentee partners.

TABLE 4-3: NUMBER OF CHILDREN

NUMBER OF CHILDREN	NUMBER OF WOMEN	PERCENTAGE
None	3	4
1	8	11
2	12	16
3	8	11
4	15	20
5	12	16
6	7	9
7	6	8
8 and above	4	5
TOTAL	75	100

Table 4-3 presents information on the number of children the women who were interviewed had ever had. The majority of them had between 4 and 5 children. Those who did not have any children explained that they were finding it difficult to become pregnant. Many of those who had one or two children were younger women and had only started giving birth. However, a few of the women with one or two children indicated that this was not their choice; they simply could no longer conceive.

Household composition was very complex. Several women lived with their husbands, children, children of their husbands' previous relationships or with the children of

co-wives. Some of the households comprised three generations. Some women lived with their children, children of their co-wives, grandchildren, nephews and nieces. Some households were composed of single siblings with their children and adopted children. In some cases single women lived with their aging mothers and grandchildren. Many women continued to live in their parental home even after marriage, or lived away from their husbands.

Most women were engaged in economic activity. Typically they were traders or farmers. These data are presented in Table 4-4. Part of the produce from their farms was usually sold in the local market for cash and was thus a source of economic independence for the women. A few of the women indicated that they were teachers, secretaries, nurses, hair dressers and seamstresses. However, the figures on occupational status can be deceptive because many of these women engaged in multiple economic activities.

For instance, one respondent was formally employed as an accounts clerk, but was also a farmer and a trader. Another interviewee was a housewife, a trader, a hair dresser and she also cracked stones in the quarries.

TABLE 4-4: WOMEN'S MAIN OCCUPATION

OCCUPATION	NUMBER	PERCENTAGE
Professional	8	11
Clerical, Sales and Service	18	24
Trader	24	32
Farmer	15	20
Labourer	4	5
No longer working because of ill health or old age	5	7
Housewife	1	1
TOTAL	75	100

Generally, the educational level of most of the women was quite low compared to that of men. A few of them (7%) had attained Diplomas in Education and Certificates in Nursing. Some of them (24%) had completed Form 4, the ten year basic education. Asked why they ended their education in Form 4, most women explained that when they were young, Form 4 was usually the highest level of education women were allowed to attain. A large number of them (31%) had also dropped out of school before class 6, the six year primary education. Pregnancy was one of the main reasons for dropping out of school. For those who did not attend school, many of them explained that their parents did not see the need to send them to school since they believed their daughters were only going to end up

in the kitchen anyway. A few indicated that they themselves were not interested in going to school.

The husbands or partners of the women were more likely to be employed in the formal sector as teachers, bank managers or clerks. Table 4-5 shows the occupations of the husbands/partners of the respondents. A large proportion of the husbands worked in the informal sector as either farmers or business people. As farmers, they were more likely than their wives or partners to produce cash crops such as cocoa, and food crops such as yam, plantain and banana. As business people, they were often cab or bus owners or shopkeepers.

TABLE 4-5: HUSBAND/ PARTNER'S OCCUPATION		
	NUMBER	PERCENTAGE
Professional	8	11
Office clerks	10	13
Business	10	13
Farmer/ Labourer	17	23
Unemployed	5	7
No partner	25	33
TOTAL	75	100

The respondents included a broad spectrum of women. While they cannot be regarded as fully representative of women in the area, they do represent a range of experiences. The sample is thus ideal for exploratory research.

PARTICIPANT OBSERVATION AND GROUP DISCUSSIONS

I also gathered information through participant observation. I lived in Kpando throughout the time of my study-five months in all-and was thus able to observe first hand many activities in the lives of women which I documented in my field diary. I speak Ewe and did not have any communication problems due to language. I had attended secondary school and also did my pre-university National Service in Kpando and thus had ties with people from my school days. My former schoolmates were able to bring me up to date on what was happening in town and gave me advice about how to go about meeting women. My friends took me to places that I had never visited before as well as introducing me to some of the restaurants in town.

I participated in many activities in the town. I had my clothes made for me, I went to the salons to have my hair done, I attended church services and a funeral. I also shopped at the local market which is held every five days. Market days in Kpando are always very exciting, and so I spent a lot of time in town on those days. This also gave me the opportunity to observe conflicts as well as the more routine aspects of day-to-day life. For example, I witnessed two fights between co-wives in the market, as well as several quarrels on the main street. The causes of such fights ranged from a women having an affair with another women's husband to malicious comments.

Living in Kpando and having previous ties to the community helped me to be in touch with what was happening in town. I had many neighbours and friends who kept me

abreast of the activity and answered my numerous questions. For instance, I became friends with a female liquor seller and a bar keeper, and spent a lot of time with her. The time spent with this liquor seller enabled me to observe firsthand some of the drinking habits of women. The location of the bar was also very useful for observing the evening activities.

My home was also strategically located, on a road to a village and people's farms. I was thus able to observe women as they walked to and from their farms and to hear their gossip and complaints about their husbands, children, relatives and friends. I witnessed firsthand what it meant to "be walking and throwing your hand into the air" or "talking to yourself," fears that often emerged in my interviews.

My stay in town enabled me to join a women's group. This was a very good way to meet many women from different social locations. The women in the group were administrators, teachers, nurses, businesswomen, presbyters and housewives. In addition to being present at some of their meetings, I was able to conduct focus group discussions with group members on two occasions with 26 and 31 women in attendance respectively. On the first occasion, the group had invited a woman to teach them crocheting. Both of us (the woman and I) were introduced. I was introduced to the group by their president as "one of our children" who had left the town for the University in Accra and had later gone on to further studies abroad. She informed the group that I had come back to learn more about women as part of my studies abroad. She formally introduced the group to me, explaining that group members aimed at self improvement, that is, they aimed to develop their potential

as women by learning more about themselves and engaging in recreational activities such as visiting places of interest. They had visited a castle, VALCO (an aluminium smelting factory), the Akosombo Dam, and had slept over and enjoyed hotel services, something most women had never experienced. They seemed delighted to meet me and to hear from someone from their own community who had been abroad. They were also willing to tell me what they knew. I was asked to provide a brief insight into the nature of my studies in Canada and to explain my research. I described my research, telling them about my general interest in women's concerns, especially their health concerns. After my short presentation, I encouraged the women to contribute to what I had said or to ask questions. Most of the subsequent discussion focused on how little time the women had to rest and their constant tiredness, themes which recurred in my interviews. They were curious to know what life was like in Canada and whether the men in Canada also married more than one wife. They asked about the nature of divorce, for instance, and wanted to know who moved out of the house when there was a divorce. On the second occasion, with the trust established from the first meeting, I listened to the women discussing their concerns and what they thought could be done about them. Apart from teaching me a lot about the complex nature of women's lives, these group meetings introduced me to many other women in the community, who I might not have otherwise met. Some of the members were later interviewed individually.

EXPERIENCES IN THE FIELD

Concerns Before Entry Into the Field

In developing an appropriate approach to studying women's health concerns in Ghana, I was faced with numerous questions and concerns. One had to do with the fact that I was embarking on research in an area where little work has been done. While substantial research has been conducted in western countries about women's health (eg. Blaxter, 1990; Doyal, 1995; Miles, 1991; Payne, 1991; Walters, 1993; Walters, Lenton and McKeary, 1995), I was concerned about the appropriateness of methods used by these researchers in a cultural setting such as Ghana, and for that matter, a less urbanized area such as Kpando.

Another concern I had before entering the field centred on the perceptions Ghanaians have about certain health problems. There is a stigma attached to mental illness due to the various explanations given for its cause. (Fosu, 1995; Ofori-Atta and Linden, 1995; Twumasi, 1975). Although I was not interested specifically in women's mental illness, I was concerned that prospective respondents might be unwilling to talk about their psychosocial well-being. Was mental health an issue among Ghanaian women? How did they understand such conditions, and how did they express them? Western scholars (eg. Walters, 1993) have surfaced Western women's uses of words like "stress" and "anxiety" in their talk about their mental and emotional states. Did we have similar words or concepts to express the reality of such experiences of health the way they are felt and interpreted in their local context?

Feminist inquiries have raised fundamental challenges to the ways in which knowledge is produced and have sought to destabilize androcentric thinking in many fields (Bleir, 1984; Eichler, 1980; Harding, 1987; Smith, 1987). In this process, scholars have proposed that it is necessary for a feminist mode of inquiry to begin with women's own experiences (Harstock, 1987:231; Hartman, 1987; Smith, 1987). Following this line of thought, it was appropriate for me to find a way of understanding a community of Ghanaian women as they understood themselves within their unique contexts. I thus had to find research methods which allowed women's own priorities to emerge. This issue was addressed as I designed an unstructured interview guide containing many prompts to encourage women to talk freely about their concerns and to take control over the interviews. In essence, the method of data collection was exploratory and very flexible in nature (Shaffir and Stebbins, 1991:5).

Apart from such intellectual issues, I was also worried about my re-entry into the community. I had once lived in Kpando, so I am familiar with the area, and I am also still fluent in the local language (Ewe). But I was concerned about how I would be accepted back into the community given my gender and my new status as a highly educated woman who has travelled outside the country, who claims to be married but has no children! In many Ghanaian communities, travelling abroad drastically changes people's perceptions about you. For instance, going to "Abrotsi" (white man's land, or abroad) raises an individual's social status. Not only is the person who goes abroad regarded as having mastered the English

language (a mark of attainment), but the person is also believed to have come back with "Abrotsinuwo" (white man's things) such as money (especially American dollars), gadgets, and clothes which are assigned a high value. There was thus the likelihood that I would be perceived in a particular light and perceived differently than I had been before I left Kpando. Many scholars have pointed to the importance of a researcher's characteristics, such as gender and class, which might influence entry into the field (Patai, 1991:137-153; Shaffir and Stebbins, 1991; Warren, 1988:60).

While discussions on methodology have provided guidelines for doing field work (Mies and Shiva, 1993; Shaffir and Stebbins, 1991; Stanley, 1990; Warren, 1988), it would seem to be almost impossible to have a ready-made technique for conducting it. This is what Shaffir and Stebbins mean when they note (1991:22):

Social science textbooks on methodology usually provide an idealized conceptualization of how social research ought to be designed and executed... As most field researchers would admit, the so-called rules and cannons of fieldwork frequently are bent and twisted to accommodate the particular demands and requirements of the fieldwork situation and the personal characteristics of the researcher.

In my situation I resolved to try to fit myself back into the community and present myself as someone who had come to learn from women whilst getting around the problems as they emerged in the field. In doing this I was reminded of Warren's advice to:

Go into the field, and live, and think, and write. Listen to what we others have said, but do not let our voices become too much the shapers of yours. It is not 'any researcher' who produces a particular ethnography, it is you (1988:65).

Gaining Entry

Gaining the trust of the community was more difficult and took longer than I had anticipated. The realization of the change in how I was perceived came initially from my contact with my family. I was no longer "Baby" (my home name), I was now "Sister" (a respectful way of addressing a young woman). This change in status necessitated a change in behaviour. In essence, I had to negotiate a new personality with my own family. This was exactly what was expected of me in the field as well (Shaffir, 1991:72-82).

Shaffir (1991:77) has pointed out, "by its very nature, field research requires some measure of role-playing and acting" in order to gain access to the field. Certainly a lot of preparation went into developing a "self-presentation" before my entry into the field. I was able to talk with my family concerning my work and they were helpful in offering advice, including suggestions about how to approach my prospective interviewees. I conducted preliminary interviews with those around me to find out what types of responses I was likely to encounter in the field. After some debate about appropriate clothing, I decided that my western dresses would do for the meantime, since I would be expected to look foreign.

Finally, in gaining entry into the field, I made use of my old neighbourhood and friends. I asked many questions about who was still around and what was happening in town, and I conducted my first interviews with friends and neighbours. I spent many hours with friends and neighbours who took me around the neighbourhood introducing me to women and I let them know that I hoped to interview some of them at a later date. I made a point of

emphasizing that I once lived and attended school in Kpando, and I let people know about my reason for coming back to Kpando. Due to the effectiveness of the informal communication network people became aware of my presence as "the woman who was asking women questions."

The introductions helped to reduce the anxiety of getting out into the field, but this did not necessarily mean that women were not suspicious of me. Living in the field and getting in touch with people does not guarantee acceptance nor does it ensure that people will be willing to participate in interviews.

Gaining the Trust of Women

Related to the problem of gaining entry into the field was the problem of gaining women's trust and convincing them to participate in interviews. Shaffir (1991:73) has pointed out that during this stage of "getting-in" one is involved in a process of educating others about one's research intentions. In my situation I had to do a lot of explaining to prospective respondents about what my research was about. Walmsley (1993) discusses how difficult and embarrassing or awkward explaining one's research project can be. This I experienced firsthand. I had to explain to numerous women that I was attending school abroad and that one of the conditions for graduating was to write a book about "something." I decided I wanted to come home to Ghana and to Kpando, to learn more from women about their health to enable me write the book. Many women expressed reservations about participating in

interviews. Some were suspicious and questioned my intentions, "How do we know you are not a government agent?" Or "What are you going to use the information for?" Others felt inadequate about what they could say, "But as for us, what do we know? Or "Ei! As for me, what can I say?" Others felt uncomfortable speaking with me, "I'm feeling shy," while others wanted to first ask permission from their partners "I have to ask my husband." Some women felt I already knew everything about women because I was educated, "But you're a doctor, don't you know everything already?" Some women also said they were too busy to participate in the interviews "As for me I'm never free." Thus women's reservations about participating in interviews ranged from being suspicious, feeling inadequate about what they could say, to not having time or needing permission to participate.

I adopted techniques depending on the situation to encourage women to participate. For instance, my use of a snowball sampling technique was quite effective in reducing the suspicion some women had about my intentions. I encouraged interviewees to introduce me personally to the women they suggested I interview next. Among women who could read, my letter of introduction sometimes was useful in establishing my credibility. A lot of effort went into assuring women of my intentions, and several of the women themselves were helpful in this regard.

During my stay in Kpando I observed firsthand the work activities of women. In many cases, their work loads were heavy. Talking about her work load one respondent pointed out that in going about her daily activities, she would walk about 10 miles. As a

result of the women's work activities, appointments were rarely kept. Women gave a number of different reasons for failing to keep appointments: a child falling ill, having to go to their farm for food or firewood, having to go to the market, not feeling well, or, as many commonly explained, "Oh! I forgot you were coming today." My first interview provided some insights into what would happen if I did not take the women's rather heavy day-to-day schedules into serious consideration. I had made arrangements for an interview one morning and had gone to do it. Earlier on the woman had explained that she was "free" in the morning after the children had gone to school and before she left for the farm. But somewhere during the middle of the interview she explained that she had to leave for the farm and the interview stopped abruptly. Apart from feeling like a failure at my work, this situation gave me an opportunity to consider carefully the conditions under which interviews would be successfully conducted. Subsequently, I arranged interview times to suit the conditions and activities of women in the field. These times often ranged from as early as 7 a.m. to as late as 10 p.m. I conducted interviews in different settings and under a range of conditions. Those who explained that they were not free when they got home were interviewed in their places of work, such as the office, in the market behind their wares, when they were processing fish or even preparing meals. I also encouraged women to visit me at my home. By taking into consideration women's work situations and allowing women to have more control over the times and conditions under which interviews took place, I was able to conduct many in-depth interviews.

The use of small gifts such as nail polish, perfume and money, acted as incentives for many women to participate in interviews. I decided to give some respondents money (typically about 2,000 Cedis or about \$3 Canadian) as many of them were poor and the interview sometimes took them away from their work. Gifts were usually given out to respondents at the end of the interviews and I made a point of stressing that they were just "thank you" gifts.

INTERVIEWER/INTERVIEWEE RELATIONSHIP

Given the nature of the research, I entertained some fears from the outset that women may not be willing to divulge their personal problems to me especially when it may involve talking about their husbands.⁷ Patai (1991:142) highlights this problem:

We ask of the people we interview the kind of revelation of their inner life that normally occurs in situations of great familiarity and within the private realm. Yet we invite these revelations to be made in the context of the public sphere, which is where in an obvious sense we situate ourselves when we appear with tape recorders and notepads eager to promote our 'projects', projects for which other people are to provide the living matter.

Phoenix (1994:50) has also warned that:

simply being a women discussing 'women's issues' in the context of a research interview is not sufficient for the establishment of rapport and the seamless flow of an interview.

It was with these cautions in mind that I devoted considerable effort to establishing good rapport with my respondents.

The first and most important effort towards establishing good rapport was to be very friendly and humble. In the Kpando context this meant, for instance, greeting the older generation as I travelled about the area. Forgetting to extend greetings might mean losing a potential respondent in the field. I got to know of how important greetings were through a neighbour. She informed me about her friend who took me for a proud and disrespectful woman because I bypassed her on one occasion without greeting her. I thus learned within the shortest possible time the politics and the immense advantage of greetings.

I also aimed to make interviewees feel very comfortable, especially when the interview took place in my house. Apart from the assurance of privacy, depending on the time, I served them snacks. Candies and cookies were always available for the children and this helped to distract them while the interviews proceeded.

To encourage interviewees to talk freely, I assured them of the confidentiality of our interview/conversation. This assurance was reinforced by my decisions not to collect their names, and to make them aware that the conversation did not have to be taped. I encouraged them to ask me to stop the tape recorder when they felt certain segments of the conversation should not be recorded. On a few occasions some of the interviewees requested that the tape recorders be stopped while they made a point. On the other hand, many of the women also enjoyed hearing their voices on tape when segments of the taped conversations were played back to them.

Although I explained why I took notes during an interview, I noticed that it disrupted the natural flow of the conversations. Apart from putting them on their guard, my note taking also meant that they sometimes stopped midway through a comment to allow me to finish writing! To resolve this problem I did much of the writing immediately after an interview or at the end of the day.

Furthermore, I had to put great effort into encouraging interviewees to talk about themselves. I probed them for more information by first asking general questions about women or about a friend and this often led finally to interviewees talking about themselves. A good opportunity to gather more information occurred after the interview was supposed to be over and the tape recorder had been turned off. Interviewees at this time usually talked about what had happened during the day and sometimes what they were feeling about an incident or a health problem.

Encouraging Interviewees to Ask Questions

Phoenix (1994:63) has mentioned that another means of developing rapport and balancing power in the interview situation is to encourage interviewees to ask questions. This technique proved very helpful in that it reduced any mystery that surrounded me. With time, I realized that interviewees were not fully satisfied with the formal introduction I gave them before an interview commenced but rather wanted more personal information. Before this approach was adopted, I had on some occasions been interrupted, or asked at the end of an

interview "Sister, can I ask you...are you married?" "How old are you?" "How many children do you have?" "Why don't you have children?" As I encouraged women to ask me personal questions, I noticed that much of the tension in the interview situation eased. The questions themselves were very interesting and confirmed the importance of marriage and family in the lives of women in Ghana.

Talking about myself also encouraged interviewees to have more confidence in the topics they raised. For instance, I mentioned that I was married but my husband and I were both in school still and did not have children. I explained that I did not have the experience they might have had and said I would be happy if they could talk to me about "life." This often encouraged them to give me a "lecture" on life as they had or were experiencing it, and they often spoke of the lives of women generally. They sometimes went further, counselling me on the "dos" and "don'ts" of married life. Thus presenting myself as a "human being" (Shaffir and Stebbins, 1991) encouraged women to feel free to talk.

Maintaining Relations in the Field

Shaffir and Stebbins (1991:145) note that "the key to success in interacting with subjects is the establishment and maintenance of rapport." In seeking to maintain rapport, I tried to keep in touch with many respondents after the interviews. In some cases, I went back to their homes (as custom demands) to thank them for their time. I also received many visitors coming to thank me for giving them gifts.

I had to deal with "domestic politics" or conflicts among women. For instance, an interviewee might not want her co-wife, or neighbour with whom she was not on talking terms, to be interviewed. The living arrangements of many of my respondents were bound to breed misunderstandings among them. Many of them lived in very big family or public compound houses, where facilities such as the kitchen, kitchen utensils and toilets (if available) were usually shared. Among other things, their children engaged in petty fights whilst playing and this often gave cause for tension between their mothers. Thus one had to be very cautious and study the "political situation" in the household before taking any further steps regarding interviews. In other cases, an interviewee might be interested in what another person had said. I was asked, "Did she tell you that she drinks?" "Did she tell you that her husband has gone in for another wife?" "Did she tell you that she nearly died last time?" In such cases I had to refuse to answer nicely by explaining that whatever we talked about was confidential. I had to ensure the confidentiality of all the information I was given while at the same time encourage them to tell me more about an interviewee with such exclamations as "really!" "What happened? Tell me."

Maintaining relations in the field was one of the most difficult aspects of my field work. In all of these cases, I had to find ways to avoid incurring the displeasure of any of my interviewees or prospective interviewees. I was not always successful. There was at least one instance in which I attempted to interview a woman who suspected I was a friend to her rival and she turned me down on these grounds.

THE STRESSES AND STRAINS OF FIELD WORK

In many respects, the perception interviewees have about the interviewer may also have an impact on the interviewer herself. Marshall (1994), narrating the stress she experienced in the interview process, has pointed out that "doing research can seriously damage your health" (1994:121). During my stay in the field, I heard from friends, neighbours, and respondents about how I was perceived in the community. I was viewed as a doctor, a social worker, or "book long" (too well educated). Others felt I was proud because I had travelled outside the country, or perceived me as rich. They also called me "big woman" or "the woman in trousers." The perception that I knew everything, or that I was a doctor or a counsellor put me in very awkward situations on many occasions. I was approached with medical problems, and my counsel had been solicited in marital issues and even in divorce. In many cases I was able to make my position clear by explaining my status and saying that I had little experience with issues such as divorce.

A related point is that research settings also involve negative feelings (Kleinman, 1991:184) or what Warren (1988:46, 47) has described as "feelings of like and dislike, boredom and annoyance, fear and shame" which are all "feelings associated with everyday life." There were instances where it was difficult for me to control my anger or frustration when I listened to interviewees narrate their experiences to me. I went out of my way on a few occasions to offer pieces of advice or financial help. Oakley (1981:30-61) has pointed to similar experiences in her study of childbirth in Britain. She pointed out that the women

she interviewed frequently asked for advice and information, and this made the traditional social science interview guidelines (which stressed that the researcher should avoid getting drawn into personal exchanges) impracticable and sometimes ridiculous. To solve the dilemma in which she found herself, she rejected the old models which were aimed at separating the researcher from the researched.

Moreover, the stress and strains and sometimes the depression I experienced as a result of so many negative stories from respondents did not necessarily leave me even after I had physically left the field. My mother's support and attention was very crucial during these times.

Finally, the physical conditions in the field can also be detrimental to the well-being of the interviewer even if she is familiar with the area. The following excerpt from my field notes summarizes some of my initial experiences:

... it's been a long time since I experienced this kind of heat! it's almost unbearable. I'm feeling sick too. I have had running stomachs, headaches, heat rashes, cold and sore throat. I hope I'll get used to all these very soon. I have arrived in Kpando. My first reaction is to board the car back to Accra. But it's impossible...oh! I'll soon get used to it again ...

The lack of such amenities as good drinking water, decent toilet facilities, good communication network such as telephones, and frequent power cuts were all strains on my welfare.

LEAVING THE FIELD

Despite some of the more frustrating experiences, I felt a sense of loss when it was time to leave the field. I had enjoyed the warm hospitality of many people, and made new friends. As Stebbins (1991:254) pointed out, we never leave the field completely in the sense that we might still be involved with our subject of study, in my case the women of Kpando. During our stay in the field, we develop close personal relationships with respondents and as Taylor (1991:246) has pointed out these relationships sometimes demand a continuous responsibility. Although my respondents knew I had just come to live among them for a few months, some of them were quite sad to realize my research time was already over and started wondering how they were going to fill the void that my absence would create in their lives. They asked questions such as "Oh! How am I going to spend my evenings?" "Do you really have to leave now?" It is difficult to phase out such personal relationships immediately. I thus continue to maintain relations with some of my respondents through letters and cards.

Writing my thesis has further made me appreciate the wealth of information I have been able to collect and to realize how much more I could have collected. Many preconceived ideas I had before going into the field were either refuted or clarified. One very important lesson I learned in the field was to go to the field with an open mind and be ready to learn. I found that being a member of the Kpando community did not guarantee my

acceptance nor full knowledge of the Kpando community. I learned something new everyday; it was an enriching experience.

In the following chapters I present the data collected in Kpando. First, in Chapter 5, I discuss the health problems women had experienced and those about which they worried. Then in Chapters 6, 7 and 8, I move on to consider how women understood their health problems and how they sought to cope with them.

NOTES

1. **Queen mothers are the female counterparts of chiefs in Ghanaian traditional societies. They function as leaders of the women and adjudicate in disputes among women. In many Ghanaian societies queen mothers also play an important role in the installation of chiefs in that they must give the final approval of the candidate selected by the council of elders to be chief of a particular community. The position of the queen mother is an ascribed one. A woman can become a queen mother only if she comes from a royal family and is the senior woman in that family.**
2. **Town Council agents are usually known as "tangas," a corruption of the English words "town guards." During the colonial period, town guards were community workers who went from house to house ensuring that people kept their environments clean. The penalty for not keeping one's home clean was often a fine or a court summons. Town guards were noted for their inconsideration and stubbornness in dealing with culprits and on that account feared by members of the communities in which they worked. This gave them a great deal of power. Presently, town guards are no longer as powerful as they used to be, but the term has retained its earlier symbolism.**
3. **The "talking drum" and the "gong gong" or "gakokoe" are traditional instruments used to disseminate information in many Ghanaian traditional communities. The "talking drum" is a traditional drum made of a hollow wooden barrel and animal hide. The hide covers one end of the barrel and is attached to the body of the barrel by strings. The other end of the barrel is left uncovered. This results in the production of a "booming" sound when the drum is beaten. It is called a "talking drum" because the different sounds and rhythms produced by the drum when it is beaten convey specific information understood by the members of the community. The "gong gong" on the other hand is a piece of a hollow metal which produces a "gong gong" sound when hit with a piece of wood. This is used by the "town crier" (a traditional messenger, usually an elderly male) to convey important messages to the community. Whenever there is an important announcement for the community the town crier gets up early in the morning, or evening, stands at certain vantage points in a village, hits the "gong gong" in order to draw people's attention, and makes his announcement.**
4. **Ghana currently has a new educational system. My reference here is to the previous educational system which was a heritage of the colonial regime. Under this system there were three levels referred to as Cycles. The First Cycle, or the basic educational level, consisted of 10 years: that is 6 years of Primary and 4 years of Middle School education. The Second Cycle consisted of the Secondary, Technical, Commercial, Vocational, Nursing and Teacher Training schools. The Third Cycle consisted of the Universities,**

Polytechnics and other professional institutions. A Form 4 leaver has thus completed 10 years of basic education.

5. See Chapter 3 for a full discussion on Market Queen Mothers.
6. "Gbotoworwor" is a traditional rite of passage for women. It is a ceremony which initiates girls into adulthood. The term "Gbotoworwor" means "the beginning of menstruation." The ceremony therefore takes place just after girls menstruate for the first time. Ideally it is expected that girls are still virgins at the time it is performed. The ceremony entails the performance of certain rituals over a period of days. During these days, libation (traditional prayers) is made to thank the gods and ancestors for guiding the girl from birth to puberty and to ask for more guidance, children, good health and prosperity. As the ceremony marks the beginning of adulthood, the girl is educated by elderly women on aspects and demands of adult female life. She is taught customary practices and values related to personal hygiene, sex, childcare and home management. A woman who does not perform this rite is regarded as incomplete and scorned by other women who have performed the rite. It is also considered an insult if a woman is married or becomes pregnant without having performed the rite. The importance attached to the rite by Kpando women is reflected by the fact that it is even performed for women before their burial when they die, if they had not performed it. "Gbotoworwor" is still practised by the women in Kpando.
7. Discussing marital problems with an "outsider" can be interpreted as an act of betrayal.

CHAPTER 5: WOMEN'S HEALTH PROBLEMS

In this chapter I focus on women's own accounts of their health problems and concerns. I demonstrate that the health problems women experienced and worried about were diverse. Their psychosocial state of being was what they mentioned most frequently in talking about their health. Some women said they thought or worried too much; others said they were depressed or always sad. They also complained of frequent headaches, fevers, bodily pains and tiredness. Many women said they suffered from other illnesses such as stomach aches, piles, weight loss, dizziness and hypertension. Reproductive health problems were mentioned less frequently. In terms of their health concerns - the problems that worried them - women were afraid of several different types of illnesses and conditions. The most frequently mentioned were AIDS, hypertension, cancer, venereal disease and heart disease, stroke, fever and stomach aches. A few women said they were not concerned about any health problem.

One point worthy of note early in this chapter is the difficulty I have discussing women's accounts of their health problems without making constant reference to the social context within which these women lived their lives. The women I interviewed almost always talked about their ailments within the context of their work activities and the social conditions in which they found themselves. So while both their words and mine do present

some of the day-to-day realities that shape these women's experiences of health and illness, I have reserved detailed discussion of the contexts and causes of women's ailments for later chapters. For now, I focus on the types of health problems women experienced and on their worries about their health.

THE MAIN HEALTH PROBLEMS WOMEN REPORTED

I asked women what health problems they had experienced. Table 5-1 shows the problems mentioned by the 75 women who were interviewed. The table includes all problems mentioned by four or more women¹. It is evident that contrary to current emphases in the literature on women's health in the developing world, reproductive health problems did not dominate the illnesses that women reported. Rather, psychosocial health problems were most frequently mentioned. In the following sections I outline and discuss the types of health problems women talked about, starting with psychosocial health problems. This is followed by a discussion of physical illnesses and lastly reproductive health issues.

The Psychosocial Health of Women: "Thinking Too Much" And "Worrying Too Much"

As indicated by Table 5-1, most women (72%) complained that they were "thinking" or "worrying too much". The 24% of women who complained that they were depressed often indicated that they too, worry or "think too much". One young woman recounting her life history, commented that she had never been happy in her life. According to her, "Since I was

born, and knew that I am a woman, I have never been happy" (int. 19:4). For her, the story of her life had been one full of hassles and problems. Her situation made her worry and "think a lot", and other women reported similar experiences. I will thus discuss issues of "thinking too much," "worrying too much" and depression at the same time.

Women complained that "thinking too much" and "worrying too much" were constant aspects of their lives. They attributed symptoms such as constant absentmindedness and difficulty sleeping to this situation. They also explained that their tendency to talk loudly to themselves and throw their "arms into the air" like a person who had "began tying one yam" (a local expression of abnormal behaviour) could be attributed to excessive thinking and worrying.

The women identified many social problems which made them "think" and "worry too much." Most of them said they thought and worried about their children, their relationships, money problems and their health. One woman explained that since the death of her husband she had been thinking a lot about how she was going to take care of her children alone. In addition, she worried about her toothache and persistent headache:

I have to look after them alone. This makes me think a lot. It's not easy, I never dreamt that this will happen to me, but here I am. The older one has finished school now, but he can't help, he is still writing exams. This is a lot of 'tukura'² for me and makes me think a lot. Now I have "taagbordor" [head problems such as headaches] when you look into my mouth now all my teeth are spoilt. When I am there³, my head will be aching. I worry a lot (int. 64:1).

Table 5-1: Women's Health Problems

	Number (N=75)	Percentage
Psychosocial Health Problems		
Thinking/Worrying too much	54	72
Depression/Always sad	18	24
Sleeplessness	8	11
Physical Health Problems		
Headache	48	64
Bodily pains	46	61
Tiredness	31	41
Fever	24	32
Feeling weak/Heavy/Numbness	23	31
Stomach problems	16	21
Piles	12	16
Weight loss	11	15
Eye problems	10	13
Dizziness	10	13
Palpitations	9	12
Malaria	9	12
Hypertension	8	11
Earache/Ear Infection	7	9
Anaemia	5	6
Asthma	4	5
Reproductive Health Problems/Conditions		
Problems related to pregnancy		
Irregular periods/Menstrual pain	12	16
Menopause	8	11
Hot flashes	8	11
Infertility	4	5

Another respondent, married and 26 years of age, was unemployed and had tried without much success to trade in a variety of items. Her description of her husband implied that he was irresponsible, because he did not fend properly for her and their two children. She explained that her baby girl was being deprived of the very necessities of life because of financial problems:

So I will be thinking, what can I do to buy my baby panties, and all that, what can I do to buy my baby earrings?⁴ And the money they are going to give you for the market will not be enough, so because of all these, I have to think about what to do to make some money to take care of the children and myself. ... Right now that I am here, the only thing I think about is what work should I do? Because if I'm working, I will not think too much and I won't be worried (int. 19:8).

A single mother of six who said her only recourse was to keep on borrowing money to care for her children expressed her frustration to me:

You'll be thinking all these, ei! This money that I've gone to borrow, how am I going to pay it back? How am I going to do this or that? How would I see to it that the children are okay? All these things make us think a lot, it's a whole lot of problem, you think and think and think. Day and night, you're thinking, you can't sleep (int. 29:3).

This woman, who lived virtually on borrowed money, was constantly haunted by her inability to pay her debts and this was a source of mental torment for her. Another woman worried because her family responsibilities were increasing. Finding herself between two generations, she had to take care of both her children and her aging parents:

Of late, I worry about my children, their education and now too, you know, my parents, they're of age, so um...the responsibility too is on me - so I think (int. 43:5).

One mother told me that she was very worried about her children whom she said were very difficult to control. Her children were always in trouble and because of this she often panicked when she saw anybody approaching her:

I worry about my children, for example, you talk to your child and your child will not listen... For example, right now that I am here, the moment I see somebody coming towards me, and I observe that the person is not a customer, my heart beats kpu! The first thing I ask the person, is 'What is the problem?' 'What has happened?' Maybe one of my children has gone to do something bad. I'm not following them, so I'm always concerned about them (int. 50:4).

She described her experience of thinking and worrying too much and even said that worrying might be fatal to her:

Yes, it worries me a lot, it worries me a lot, if you're not patient, this makes many women worry, and if you don't take care, you can pass through that and die because you're always worried, your heart is never free... Because you see right now, when I worry or think too much, I get this severe headache. When my head is aching like that, then my neck also starts paining me, then I start experiencing the pain at my back, then my stomach, and this will continue to pain me for a long time before I feel better. Because I have thought about the issue too much, my heart will not be free, so when I lie down and sleep and wake up like that around 12 midnight, I won't sleep again until day breaks (int. 50:5).

Another woman whose son was suffering from epilepsy explained that she was very worried about his welfare:

I think a lot ___ Hmm ___ I think a lot, especially the fifth one [son] who has that illness, he is now spoilt [disabled]. I think If I say I don't think, I'm telling lies (int. 63:4).

A woman whose husband had become verbally abusive described how she often became absentminded as a result of thinking too much:

I get very worried, sister, it's not easy. I will be there aaaah [for a long time] thinking and thinking, I'll be worried, what can I do? When it happens that way, I'll just end up becoming something [not being myself], I'll just be there⁵, because as I am here now, there's nobody to go to and say this is what is worrying me, what can I do? So me alone, I'll be there, I'll go and lie down in bed like that, and be thinking and thinking, and then I grow thinner and thinner (int. 7:6).

One of my respondents who was 35 years old and had never had a child said she was usually depressed. Any happiness she experienced was overshadowed by her situation of childlessness:

I'll be happy like this ... but after some time I remember my problems then my happiness will stop immediately, then I'll sit down quietly and start thinking (int. 9:4-5).

Similarly, a young woman who was finding it difficult to get pregnant said she was often depressed and there were times when she withdrew into herself:

I worry, and I'm usually not happy. When I remember that I can't get pregnant I feel sad, so it's not every day that I'm happy ... I'll just be there, quietly, I won't talk to anybody (int. 54:4).

One woman described her suffering and constant, painful "thinking" in relation to her daughter's death:

When she died, I nearly became a mad person ... I felt I was going mad! I thought so much that I didn't know what to do ... When I'm there I'll be crying, crying ... it's a lot of pain for me especially when I see her age group, I feel so sad ... I feel a lot of pain in my heart, it's so painful, and I think a lot. I will ask myself, ah! What did you do? Why should she die? Didn't I take good care of her? What should I have done? (int. 62:2).

Many women said the experience of worrying and thinking too much made them lose weight. One woman who had children who were difficult to control argued that anybody in her situation would worry, find it difficult to sleep and even lose weight:

If it were you, you'll always be worried, even if you're fat, you'll lose all the weight. If you sleep, you can't sleep deeply (int. 50:5-6).

For most people in Ghana, to be thin indicates suffering, depression, hunger, malnourishment or illness.

According to many women, the main impact of thinking or worrying too much was that they found it difficult to sleep. As one woman said:

I think a lot ... in the night too when I go to bed, I can't sleep. I'll be turning and turning on my bed ... I have observed that it is the thinking that is causing all this sleeplessness... (int. 64:1).

A widow attributed her sleeping difficulties to her worry over a string of interrelated problems. She had lost her husband a few months earlier. Also, her unmarried teenage daughter had given birth to a second child and had yet to settle the hospital bills because she had been unemployed for several months. She herself was recovering from an illness which had kept her bedridden for nine months. She described her problems with sleeping:

Sometimes, I wake up and sit on the bed, I can't sleep, you won't even feel sleepy. One day, I sat there until morning. Sometimes it continues for three days. I will be hearing everything, I can't sleep, I don't know why. Then I'll be asking myself, is it because of the thinking? (int. 2:33).

For this woman, a tranquil mental state is a prerequisite for a "good sleep." One whose "brains are always busy," however, is bound to experience sleepless nights:

So you see, thinking is all I do, I don't sleep at all. I don't sleep at all. If you don't have peace of mind, you don't know what to do. Every time 'susu' [brain] is always working, 'susu' becomes bigger than you yourself, hmm ____ that is how I live. You know, if you're a woman and you don't have your needs, you'll always be worried (int. 2:9).

One respondent's inability to provide her family with a balanced diet as a result of inadequate financial resources caused her many sleepless nights:

So when we have money problems like that and their [children's] food is not good, it worries me 'paaa' [a lot]. It worries me paaa. It doesn't make me sleep, I can't sleep in the night. I'll be praying that Jesus, I'm begging you, listen to my needs. When it happens like that I can't sleep (int. 5:9).

She concluded:

I can't sleep. It's something that worries me a lot. Sometimes I'll see that I need something 'paaa' [very much], but I know I cannot get it. 'Etiede dzinye paa' [it worries me a lot], I can't sleep (int. 5:10).

Another woman with an absentee husband made a similar comment:

What will the children eat? What will they wear? One of them is sick, she has to go to the hospital, where do I get the money? ... So every time you are thinking. When it's night and I lie down I won't sleep (int. 8:3).

Sleeplessness was thus quite common among many of the women who talked to me.

In fact, one of the women joked that Kpando women could become security officers because many of them suffer from sleeplessness:

Some people complain about the fact that when it is night and they go to bed, they can't sleep, or they just sleep for some few hours and they cannot sleep again till morning ____ and I used to laugh at them and tell them that they better become "watchmen" [security officers] (int. 33:3).

While this woman found some humour in the situation, it is important to note that in many Ghanaian societies women wake up and begin their daily chores at the first cock crow (about

2:30 or 3 a.m.). Viewed in light of this tradition, the problem of sleeplessness is a grave one, for it implies that many of these women hardly sleep at night in spite of their demanding daily schedules.

The women I spoke with identified several ways that "thinking" or "worrying too much" and sleeplessness was "bad" for them. It could lead to unusual behaviours. For instance:

Sometimes you'll be thinking and thinking. If you sleep in the night you can't sleep. You're going to the farm too, you alone, you are talking on the way. You'll be talking and talking, you'll even forget yourself and wouldn't know you've even got to the farm [laughing]. Or somebody will ask you, 'What's wrong?' Then you'll say 'aaah, taamebubu' [thinking] has made me to be talking oooh (int. 1:25).

The practice of talking out loud was often accompanied by women throwing their hands into the air:

You'll see some people going and talking, and will be throwing their hands into the air...Some people will be going, they'll not be sick, but they'll be suffering from mental problems. They alone will be talking in the air, 'hahia tededzi' [her needs are too many], 'enu tikorne' [she is fed up with these problems], so as she is going along she is talking (int. 5:12-13).

One of the women who was a trader, told me that when she became bankrupt she could no longer sleep. She also started walking about aimlessly:

When I go to bed, I can't sleep. I'll go and report to the doctor and he'll give me Valium, 10 milligrams. I can come and take 3 tablets, but still I can't sleep ... I have even taken 4 tablets before ... even then I couldn't sleep ... I realized that I was no longer myself. I can stand up here and walk all the way to Konda [a village outside Kpando town] and then just walk back, and wouldn't know why I went there (int. 66:7).

Since I lived on a road that led to some small villages and farms, I overheard women "talking loudly" to themselves and saw them "throwing their hands in the air."; some of these women were walking alone.

It is clear from the above discussion that psychosocial issues were very important to most of the women I interviewed. Almost three quarters of the women spoke about "thinking too much" and "worrying too much." Their mental distress was understood to lead to many problems, including absentmindedness, difficulty sleeping, "abnormal" behaviour like talking to oneself and throwing one's hands in the air, and weight loss. Difficulty sleeping was a particular problem, as it was seen to intensify other consequences of mental distress. Many of the women related their anxiety and unhappiness to the conditions of their lives. They spoke about worrying about their children and their parents and about financial difficulties. I will discuss the relationships between social conditions and health problems in greater depth in later chapters. The next section of this chapter continues the discussion about women's illness by focusing on physical health problems women reported.

Physical Health Problems

As Table 5-1 indicated, women reported suffering from a range of illnesses and conditions. Many of the physical health problems they identified were day-to-day low level health problems such as headaches (64%), bodily pains (61%), tiredness (41%), fever (32%), general weakness (31%) stomachaches and stomach ulcers (21%) and piles (16%). Women described these health problems passionately and sometimes went into graphic detail in order

to convey how the illness affected them. In particular, older women and those experiencing the illness at the time of the interview gave vivid descriptions. When I arrived in the home of one respondent, I found her lying on the floor complaining about a severe headache. She described how she felt:

My head! My head! My head will ache 'kpla, kpla, kpla, kpla!' I'll be there and my ear drums will sound 'kplo!' I won't hear anything again, I will be hearing 'wo wo wo ooo' inside my ears, oh! What is this?! I will put my finger into my ear, no! That's the illness I have (int. 63:1-2).

Another woman said: "What worries me is my head, and then the inside of my ears will be sounding 'wuu wuu wuuuu'" (int. 61:1). Other respondents gave similar descriptions.

My head is worrying me ... my ears ... there's sore in my head so my ears get blocked ... When the sun is shining like that my ears will get blocked, even when people are talking to me I won't hear (int. 1:14-15).

One woman said her headaches were so severe that she had to tie her head with a cloth:

When I think like that deeply then my head will ache me terribly. Sometimes I have to tie my head to feel better (int. 6:8).

Headaches were a major aspect of women's lives. Many of them said there was not a single day that they did not have a headache. Headaches were sometimes experienced in combination with other illnesses such as fever, malaria or bodily pains.

As the above quotes suggest, women experienced not only one illness, but rather several health problems at the same time. A 40-year-old woman talked about a combination of health problems. She said she suffered from headaches, fevers and abdominal pains as well as a skin disease every dry season:

I think, the thinking brings me headache and all that to me ... My lower abdomen also pains me, fever too and all that, and when it's 'Harmattan' time [a cold dry wind often dust laden which blows across the Sahara between December and March], my legs become dry and peel off, they are things that worry me (int. 50:7).

Another woman complained that she suffered from severe headaches, piles, stomach aches and chest pains:

First I experience severe headaches, secondly, I suffer from kooko [piles] . My stomach aches, my chest, they say it's not 'gbohe' [asthma], but I find it difficult to breath properly (int. 16:6).

As many as 61% of the women complained about pains and weaknesses in different parts of their bodies, such as the back, knee, thigh, leg, arm, waist or joints. An old woman for example complained about having severe pains in her waist, thigh, legs and knee. She exclaimed:

My waist! Right now my thigh!...I can't walk, if I attempt walking, I feel pains inside my bones, and my legs, those threads [ligaments] inside my legs, they pain me... I am even feeling the pains at this moment, I'm feeling the pains, especially when I lie down in the night and I bend my knee and want to straighten it again, oh! The pain is unbearable (int. 33:1).

Forty-one percent of the women also said they were usually tired or suffered from fatigue. Others said they felt dizzy or weak, which they expressed as "my whole body becomes heavy." Other women described numbness in their bodies. This woman experienced hers in her feet:

Sometimes my feet becomes numb, I won't feel anything, 'Ananse' [spider] will hold my feet, I can't move it (int. 61:1).

Another person experienced numbness in her whole body:

The sickness which I suffered from was like 'ebo,' like how 'Ananse' [spider] has caught your feet. You see how you will sit down for a long time and then your feet will become numb and you'll not be able to walk, you won't feel anything, that was what happened to my whole body ... Up till now it has not finished completely in my feet (int. 2:23).

Another health problem some women reported was high blood pressure. A woman suffering from hypertension believed her persistent worry and sleeplessness contributed to it:

This kept going on for a long time. I fell ill and went to the hospital, my blood pressure was taken again and it was very high. So thinking, worrying, these are the things that caused my high blood pressure, now I'm always sick. Despite the fact that I have tried to forget about all these, I try to think about my problem by saying that all those things are earthly things, but I can't stop worrying. Sometimes you try, but you can't help it, I hope you understand? (int. 66:7).

Other women suspected that they might be suffering from high blood pressure but were not sure. They had not gone to the hospital for examination to confirm or disprove their suspicions. They said their symptoms were similar to those who were suffering from it. They mentioned symptoms such as heart palpitations:

My heart beats 'kpu, kpu, kpu.' When I walk for a short distance my heart will start beating very fast (int. 66:7).

A 56-year-old woman described her palpitations in the following words:

Last time too when I was lying down, I heard my heart beating in my head 'kpla kpla kpla kpla!' When it happened I got scared, I got out of bed and sat down (int. 30:3).

Women's complaints about their bodily pains, fatigue or tiredness and high blood pressure were passionate because they said such conditions prevented them from going about

their activities. Their complaints about these ailments were almost always couched in terms of their daily activities. They said the pains they experienced prevented them from going to the farm, trading, carrying loads or doing other household chores. A 33-year-old woman explained that she used to wake up very early and do her chores but she was no longer able to do that because she got tired easily:

Because I'm no longer myself, I can't work the way I used to work. Those days I used to wake up and do all my work, but these days, I'm no longer active. I work for some time, and then I get very tired. When I walk for some time too I get very tired, so these days I feel weak (int. 16:8).

Another woman, 42 years of age, who had four children explained that her feeling of heaviness made it difficult for her to do her laundry or go to church:

My whole body becomes very heavy ____ you see the things I'm washing now, I will be postponing it from morning till evening, you'll not be feeling healthy, you'll be feeling very heavy, you can't stand up to do anything. On Sunday like this, you'll like to go to church, but you can't even stand up and fetch water and bath and go. So all the time you're dull, then people regard you as a lazy person (int. 14:6).

A woman who said she suffered from bodily pains and fatigue described how helpless and frustrated she felt as a result of not being able to do all her household chores herself:

I used to do a lot of ironing of my things and that of my husband too but now, I can't stand up for too long. So I do just one and then I stop and then I ask somebody to do it and I'm never satisfied with the way it is done. So every time I'm getting more and more annoyed (int. 18:9).

A 50 year old trader who had been ill for several months explained that she worried because her different health problems made her inactive:

I worry ____ the reason why I'm worrying so much is the fact that the illness is not making me free... I don't know why I should be suffering like this, all the time. I have some pain somewhere. Sometimes I can be immobile for one month. Sometimes. I can't even get out of bed. These are things that make me worry of late. When I'm able to move around, I don't worry so much, because I'm not used to staying at one place (int. 66:7).

One woman complained that her doctor did not treat her symptoms properly when she miscarried. As a result she was constantly tired and less active. This she said made her sad:

I'm no longer happy, because I'm no longer active ... Those days I used to wake up early and do all my ups and downs [daily chores] but these days I'm no longer active, I work for some time and then I get very tired, when I walk for some time too I get very tired, so these days I feel weak (int. 16:7-8).

The pain, tiredness and weakness that they experienced prevented them from tending to their daily activities such as fetching water, cleaning the home, taking care of the children and going to the farm or market. These are essential responsibilities and activities that most women cannot afford to postpone or delegate to other members of their families.

The above discussion has shown that in addition to psychosocial health problems, women also reported an assortment of low level physical health problems. Headaches were a common feature of many women's lives. Others described ailments such as pains in various parts of their bodies, fatigue, weakness, numbness and hypertension. The passion with which women described their physical ailments reflects the ways that physical health problems interrupted their daily work and activities. Physical health problems were seen to interfere with women's essential responsibilities, and could thus disrupt household organization. The

next section of this chapter focuses on the health problems reported least frequently, those related to reproductive health.

Reproductive Health Problems

Contrary to the observations made by many studies on women's health in the developing world, very few of the women in my study reported gynaecological health problems. Of the women who did report reproductive health problems, some women complained that they experienced menstrual cramps or irregular periods. A 35-year-old woman complained that she was not getting pregnant. Another person said she had been trying to get pregnant for the past seven years. A woman who had a baby when she was a teenager said she could no longer get pregnant because her fallopian tubes had been cut as a result of an ectopic pregnancy.

Some of the women who had children recounted how difficult it was for them initially to conceive children as a result of experiencing miscarriages or ectopic pregnancies and stillbirths. This 36-year-old woman described her experiences of miscarriage:

Anytime I got pregnant I miscarried. I didn't understand it. I was four months pregnant, then I dreamt that somebody was putting her hands into my vagina into my abdomen. I started bleeding when I woke up. So I was taken to the hospital, but I miscarried. Another one too, I was seven months, a baby girl, she also died. The third one, about three months, the same thing happened ... Then something big started growing inside the lower part of my abdomen. They started boiling some herbs for me and with time the whole thing vanished. After that I got pregnant and miscarried again. My mother said she had never heard this before, so I should go and see a gynaecologist ... So I started visiting this doctor. One day he took me to the theatre and made D and C for me. He said some part of my womb

was opened so I should come back when I get pregnant again ... When I got pregnant I was on constant observation until I gave birth to my first child. Everybody was surprised when they heard that I have had a child (int. 12:7).

In addition to episodes of miscarriages, some women also talked about losing their babies at birth. Others said they were usually sick when they got pregnant; some said they vomited throughout the nine months. Others said they felt weak and could do very little during those times.

Apart from health problems directly related to pregnancy, some women complained of vaginal infections. A 40-year-old woman said she often experienced severe itching in her vagina:

And there's another illness too, when I'm there, my womanhood [vagina] will become like 'today's illness,' It's something that appears on children's heads, it's like sores, it will be itching, and itching for a long time. This is very common among we females in this town. When you're there, your vagina will be itching, you'll apply hot water to it. When it comes to a time, you can't even apply the hot water to it again, it becomes a sore to the extent that you'll experience a lot of pain when you go to urinate (int. 50:7-8) ⁶.

An older woman also complained about a growth in her vagina:

When I stopped having children, I noticed that something has grown inside my womanhood [vagina]. It is inside there, big, round ____ I can feel it (int. 63:1-2).

One aspect of reproductive health that featured in women's conversations was menopause. Eleven percent of the women had gone through menopause and they talked about their experiences. They complained that they were starting menopause at a younger

age. A respondent whose periods had stopped before the expected time spoke of her experiences as follows:

- r: Emm ____ (fidgeting a little) You see, right now that I'm here, I have stopped having my 'gborto' [literal translation: 'outskirts of town,' meaning menstrual period] abruptly.
- i: Aha
- r: You see, abrupt menopause like that too is bad.
- i: Aha
- r: Your whole body will be paining you every day, because it's not yet time for me to stop 'gborto' before I stopped ... so my whole body will be aching, your waist, and it worries me (int. 2:27-28).

In describing the symptoms of menopause, women complained about "heat", palpitations and bleeding intermittently. The above respondent mentioned that her friend who had also stopped having her period "too soon" was experiencing hot flashes:

I have a sister [friend] down there, she has also stopped having her 'gborto' [period] and she says if she is there, her whole body becomes very hot, she wouldn't know what to do, she has to remove her dress before she can sit down (int. 2:28).

Another woman complained of hot flashes and bleeding intermittently when she was experiencing menopause. She described her experiences of hot flashes vividly:

My body! I used to feel it in my body 'kpu kpu kpu kpu.' My body will be hot, I will be pouring cold water on myself. I will always carry a cold towel around during that time too. I can have my period three times within a month ____ and then with time, I stopped having my period. (int. 62:6).

In describing her experiences one woman mentioned a combination of symptoms. She said she had hot flashes, felt like fainting and had, menstrual cramps, severe headaches and palpitations:

What I experienced when I was about 52 was just a flush of heat, and at times I felt like fainting. I get exhausted easily, the little thing I do I feel tired, something little, I feel tired ____ and cramps ____ severe headaches and palpitation, that's all (int. 28:7).

These symptoms of exhaustion, hot flashes, and severe headaches recurred in the accounts of menopause.

A highly educated woman who spoke English well said she had been reading a lot about women's health and believed that all her health problems were caused by the fact that she had reached menopause:

- r: My back, it looks as if I'm getting old (laughing)
 i: Not yet
 r: But I understand it should be so, because emm ____ I have read a lot about this stage where I've reached.
 i: Yah
 r: I have entered my menopause
 i: Aha
 r: And I think this is responsible for a lot of the things that I feel are wrong with me, but emm ____ much as I say I wouldn't think about it, I still do, because it's painful. For instance, I'm not as fast as before, and now and again I feel a lot of aches in the groin, the legs, in the knee, that kind of thing. Then I just get annoyed, these are all normal things, but they are worrying, they are cause enough to worry about, so that is my worry (int. 18:8-9).

She continued to talk about the pain she experienced and her frustration with her doctor:

I'm now 54, my legs, they ache, sometimes I feel my muscles are pulling, ah! Then the waist, Oh! It's not good, you can't even describe it. Whenever I go to the doctor, he only laughs at me, so I've stopped going to him because I felt he has not been taking me seriously enough (int. 18:10).

She also mentioned that it was difficult to go on with her normal work life because of her aches and pains:

And then in the office too, people... While you are thinking about your aching knee, somebody will also come to you with their problems and will not understand you. The patience! The patience is not there, so these are some of the things, so you might be tempted to raise your voice louder than before (int. 18:9).

This section has pointed to the fact that reproductive health problems were among the ailments women experienced: some women found it difficult to have children, others had miscarriages and the older women narrated their experiences of menopause. Overall, however, reproductive issues did not dominate the health problems women reported, it was rather the psychosocial and physical health issues that women said affected them most. I will focus my discussion now on the types of health problems women were concerned about.

WOMEN'S HEALTH CONCERNS

I asked the 75 women I interviewed what health problems they were worried about. All concerns mentioned by four or more women are shown in Table 5-2⁷. More than half of the women interviewed were concerned about some form of reproductive health problem. Fifty-two percent were concerned about AIDS and 11% worried about other sexually transmitted diseases. Forty percent of the women were concerned about hypertension, 16% about cancer and 8% about heart diseases. Twelve percent of the women interviewed, however, were not concerned about any health problem. While the health problems that women experienced were low level everyday health issues, they were worried about illnesses

Table 5-2: Health Concerns Reported

	Number	Percentage
Psychosocial Health Problems		
Mental illness	4	5
Physical Health Problems		
Hypertension	30	40
Cancer	12	16
Heart disease	6	8
Fever	5	7
Stomach aches	5	7
Stroke	5	7
Asthma	4	5
Death	4	5
Diabetes	4	5
Headache	4	5
Eye problems	4	5
Weakness / Tiredness	4	5
Reproductive Health Problems		
AIDS	39	52
Gonorrhoea / Syphilis	8	11
No Health Concerns	9	12

and diseases that were more likely to be life threatening. It is also interesting to note that while the health problems women experienced were mainly psychosocial in nature, such

issues did not emerge in discussions about their health concerns. In this section, I will focus on the health problems most often mentioned as worrisome.

AIDS stood out as the disease most feared by the women I interviewed. One woman exclaimed, "Everybody fears it!" because "it is a bad disease." AIDS has many names. It is called "today's illness" and "modern disease", apparent references to its recent history. It is also called the "in-between the fingers disease." This name stemmed from a locally held belief that one important symptom of AIDS was the "rotting" of the skin between the fingers. It is also called "travellers' disease," because it is believed to have been introduced by people who went abroad. A common reference to AIDS among the older generation was "Yeys," an obvious corruption of "AIDS." According to them, "Yeys" kills people. They say if you get it, you will die and you will die a bad death. It will make you "basaa" [mess you up, or distort your life]. AIDS is thus a "bad" disease because it dehumanizes whoever gets it before the person's death. Women were particularly concerned about AIDS because it is difficult to detect since HIV, the virus associated with AIDS, does not have any obvious symptoms:

You may not even know at first, it is not going to prick you like a pin for you to know at once, so that you try to do something about it (int. 12:5-6).

All types of women expressed fear of AIDS. The only group of women who seemed unconcerned about the illness were the elderly who were either widows or no longer married and who were less likely to have sexual partners. Currently married and single younger women expressed the greatest fear of AIDS. A single woman who spoke to me expressed her worries in the following words:

I don't have a husband, but by all means, who knows, I will have a boy friend somewhere, and maybe he has gone to other places [been with other women], and I don't know, and if I should sleep with him, it's possible that I can get it. So I fear that a lot, even more than any other illness (int. 29:4).

For this woman, being single increased the possibility of contracting the disease. But married women had similar fears. According to one, even women who are "faithful" to their husbands are at risk:

You know what I fear most, because of my husband, AIDS. AIDS too is a very dreadful disease, that even we married women are afraid, because you as a woman, you're in the house with one man, but your husband has two or three women outside the marital home, and these two, three women that he is flirting [having sexual relations] with, you don't know how safe they are. So even we married women we stand the risk. Yes, because you're sure, you're very sure that 10 years, even 100 years, you will not have the AIDS, 'but as you're in the room, your feet are outside' ... (int. 43:9).⁸

In this woman's view, being faithful to one's husband was no guarantee of safety. At the same time, women saw it as incumbent upon themselves to avoid AIDS; they also felt that if they contracted the disease, the responsibility was theirs. A typical respondent expressed her opinion:

Emm ____ If it's an illness that I should worry about then it must be something I myself must invite, like this common illness - AIDS (int. 10:7).

This 36-old-woman who said her absentee husband was mistreating her had contemplated having an affair. Her fear, however, was the possibility that she might in the process contract AIDS:

Now, I fear AIDS, because right now that I am here, because of my 'tukura' and the too much thinking, and the problems that my husband gives me, it makes me think that maybe, I can get somebody to be my lover, someone who will help me too. But today, because of this illness, it doesn't occur to me

to look at another man even if they are making advances at me. Although my husband is not treating me well, I have not even thought about marrying again. I don't know whether that person has a disease. I am already with this man, even if he is roaming [having other sexual relations]. I will not be the source of the disease, he will be the source, that's why I fear, I fear it a lot... When I go out, I can be approached by a man, but I'm afraid to say yes (int. 12:5).

The woman was willing to be in a "bad" marriage if this would prevent her from contracting the disease.

In addition to AIDS, many women were also very much concerned about physical health problems, in particular, high blood pressure, known as "Wusorgbor" (literally meaning "plenty blood"). They had believed that "wusorgbor" was the illness most commonly affecting women in the community. Many respondents knew somebody who was suffering from it, for example, a mother, grandmother, relative or friend. Women feared high blood pressure because they believed that the exigencies of their day-to-day experiences predisposed them to the illness. Some women expressed fear that their constant "thinking" and "worrying" could induce high blood pressure:

Women do a lot of 'tukura' worrying too much, thinking too much, you put your mind here and there all the time, that's what I think causes it [high blood pressure] (int. 16:8).

They were also concerned about high blood pressure because it was unpredictable, that is, it did not seem to follow the generally accepted beliefs about those who were likely to suffer from it. This woman said how puzzled she became concerning the cause of the illness:

They say that these days you don't even have to be fat to suffer from it. You can be as small as anything, but you'll hear that the person is suffering from it, and I don't understand, I don't know why, so I fear it. I've been asking, and

they used to tell me that worrying too much can cause it, thinking too, or some types of food that we may be eating (int. 30:4).

An old woman said she was afraid of hypertension because she not only "thought too much," she also seemed to have some of the symptoms:

Yes, I fear it a lot, because I'll just be there and all of a sudden some heat will engulf me, I will be feeling very hot, my head will start aching, so I fear it (int. 63:8).

According to her, it was generally believed the illness affected overweight people but from her observation it was common among thin women as well. This apparent discrepancy made it more difficult to understand why people got the illness or who was at risk:

and I have learnt that you don't have to be fat to have it, even if you're very small too you can get it ... I fear it a lot, I pray I don't get it, they have not told me that I have it (int. 63:8).

Another woman said she was afraid she might be suffering from high blood pressure because of her heart condition:

The way my heart beats, 'kpu kpu kpu kpu' and then I become tired, so I think they are symptoms of high blood pressure (int. 61:1).

Women were also concerned about cancer, especially cancer of the breast. Many of them felt helpless because apart from it being a "bad" illness, they did not know the cause of breast cancer. A woman expressed this uncertainty in the following words:

For cancer, I don't think there is anything one can do as such to prevent it and then of course they talk about smoking which I don't do. But that one is a matter of giving it to fate (int. 18:11).

Cancer was thus a health problem women said they were not suffering from, but which concerned them a great deal.

A few (12%) of the women said they were not concerned about any health problem. Among this group were those who could not recall any illness that they feared. Others said they did not think about health problems because they believed that by thinking about illnesses they could end up getting them. Others said they had just made a decision never to be afraid of any illness.

While reproductive health problems were reported infrequently among the health problems women experienced, over a third of the women mentioned that they were worried about certain reproductive issues. Among the health concerns they identified, AIDS was clearly the illness most feared. Women were most concerned about AIDS because their partners often had other sexual partners. Women also feared hypertension and heart disease, which were thought to relate to worrying and "thinking too much." Some of them were also worried about cancer. Generally, the health concerns identified were more likely to be life threatening than the health problems women had actually experienced.

SUMMARY AND CONCLUSION

This chapter has identified and discussed the health problems and concerns raised by the women I interviewed. In the first section I focused on the health problems women had experienced. It is clear that the psychosocial health of these women is very important to them. They frequently talked about "worrying" or "thinking too much." They also said they found it difficult to sleep and felt that they sometimes behaved in an unusual fashion. These mental health problems led to significant day-to-day health problems. For many of the

women, headaches, which they mentioned as a frequent illness, were caused by "thinking" and "worrying too much." Women also said they suffered from physical illnesses such as fevers, bodily pains, and tiredness. These physical illnesses sometimes made it difficult for them to go about their daily activities. While women reported that they suffered from illnesses that could be described as low level everyday health problems, the illnesses they said they were worried about were more likely to be life threatening: AIDS, venereal diseases, hypertension, cancer and heart diseases were prominent among the illnesses that women said they feared most.

It is striking that reproductive health issues did not dominate or feature prominently among the health problems that women said they experienced. Insofar as women worried about such issues, it was in relation to AIDS and venereal diseases and, in consequence, their relationships with men. These findings present a somewhat different picture than that apparent in the literature on women's health in the developing world, where reproductive health in relation to pregnancy and child health is the most prominent women's health issue. In the chapters that follow my focus shifts to the ways in which women understood and explained the health problems they had experienced. From their accounts we will see how women's health is shaped by the social and material conditions of their lives.

NOTES

1. In addition to the illnesses mentioned in the Table 5-1 a few women mentioned that they suffered from physical illnesses such as toothache, jaundice, pneumonia and skin disorders. Two women said they had sickle cell anemia while one old lady had a partial stroke. In terms of reproductive health problems, two of them suspected that they might be suffering from a vaginal infection, one said she had a weak bladder and another had been experiencing pains in her breasts.
2. "Tukura" was the term women used to describe the multiple demands and expectations they face everyday. There is a more detailed discussion on "tukura" in Chapter 6.
3. "When I am there," "right now that I am here" or, "as I am here now," are local ways of saying "even at this time", "at the present moment" or when I feel like that.
4. It is the practice in Ghana for females to wear earrings. This is a way of differentiating women from men. It is also said that wearing of earrings makes women more beautiful.
5. "I'll just be there" is a local expression indicating a feeling of helplessness.
6. In this context, "today's illness" is a local name given to a fungus infection that affected the scalp of children leading to loss of hair on the affected sections of the head.
7. A few women were also concerned about illnesses such as bodily pains, epilepsy, tuberculosis, meningitis and rheumatism.
8. This is a proverb meaning that nobody can be absolutely sure about their safety. In this case, the woman was saying that they may not be as safe as they thought from contracting the AIDS virus because their husbands often had multiple sexual partners.

CHAPTER 6: HOW WOMEN UNDERSTOOD THEIR HEALTH

As I noted in the previous chapter, it is difficult to discuss women's accounts of their health problems independent of the social context within which women live their lives. This is because the health problems women experience are embedded in the circumstances within which they work, maintain relationships and take care of their children and other dependants. In this chapter I will show how women constructed their health; how they linked ill-health with these aspects of their lives. This provides us with clues about the way in which ill-health is socially produced and linked with women's roles in social reproduction and production.

Women perceived their health in holistic ways. They related their health concerns to the social conditions in which they found themselves. In talking about their health, women mentioned their heavy work loads due to their multiple roles, the harsh environmental conditions under which they have to perform these activities and their poverty. They also pointed to the strains they experienced as a result of their status as single or married women and the stresses of relations with their children, family members and other members of the community.

The analyses of the data suggest that Ghanaian women understand their health in ways that are complex. For them, health is connected to life and not "something out there."

They saw their health as intertwined with their lives and so they rarely talked about one topic without the other. The reality of the Ghanaian woman's day-to-day life impinges on and informs her understanding and definition of health. Women mentioned the nature of their work, financial situations, relationships with partners, children and relatives as major causes of their health problems.

In this chapter I will show how women constructed their health by connecting it to their work and financial situations. The following chapter will examine women's relationships and the impact they said relationships had on their health. Since women constructed their health concerns within the framework of their day-to-day lives it is helpful to start this discussion by describing something of these lives.

WOMEN'S "TUKARA"

Women described their lives and the lives of other women in terms of the daily difficulties that being a woman entailed. "Tukara" was the term they used to capture the demands of women's daily experiences. The women I interviewed talked about the multiple expectations and responsibilities they have as women, including their heavy work loads and the multiple work activities they engage in for the upkeep of their families. The degree of "tukara" varied in accordance with the specific circumstances in which a woman found herself. The conditions of being married, single, divorced or widowed all entailed some degree of "tukara." Each of these statuses was associated with numerous particular

responsibilities and expectations. Married women talked about "tukara" in connection with their relationships with their partners, children, in-laws and other relatives. The single, divorced and widowed women I interviewed explained that life was not easy for them either and the burden of looking after their children was an issue they talked about extensively. They pointed out that their situations as women and workers were illness-producing.

The term "tukara" was used extensively by the women in describing their lives ¹. "Tukara" describes a variety of activities women engage in and also characterises the circumstances under which they live. Women explained "tukara" on different levels. For the most part they used the term to refer to their various daily work activities both at home and outside the home:

The 'tukara' in women's lives is that, you wake up, you sweep, you go to fetch water, you see to the children, you make fire, you cook for them. Then you prepare and go to the farm, you get to the farm. You work until you are tired, you close, and then you set off for home. When you return, you go and fetch water. After that you go to the market, and then you come and cook supper. By the end of the day, you are tired (int. 57:4).

In her explanation of "tukara" this woman would seem to be using the term in a general sense to refer to her daily routine of work activities. Other women were more specific. They related their "tukara" to the hassles they had to endure in order to make ends meet, often without much success:

The way I understand it ['tukara'] is that, you are doing this and doing that, but the money is still not enough, or you are not getting money at all . You don't get enough despite the fact that you work hard ____ poverty, some women work very hard, but they can't make ends meet. You are worried, you

force yourself to do this and that at the same time. You'll be thinking, when you go to bed, you can't sleep. The reason why I say I understand it this way is that, for example, you see what I'm selling right now, if this were enough to take care of the home, I won't lie down in bed and be thinking about what else I should do to get money, or where will I go to get more money? But this alone is not enough, so I'm always thinking about other things to do. I farm too (int. 36:10).

For other women "tukara" also meant the constant effort of monitoring and admonishing their children's behaviour:

Um, 'tukara,' ... your children don't listen to you, so every time your heart is not free, you keep saying 'don't do this, don't do that,' all this is 'tukara' (int. 16:4).

The major recurring themes in women's accounts of "tukara" were their heavy work loads; poverty or persistent financial problems; and the numerous hassles they had to go through to maintain their families and control their children's behaviour. For many these problems were created or compounded by badly behaved children or irresponsible husbands.

An Unequal Division of Labour

The women I spoke with emphasized the differences between men's and women's "tukara." A common tendency especially among married or formerly married women was to contrast their responsibilities and activities to those of their partners in order to demonstrate the unequal division of labour between men and women. In the following words a typical respondent presents a picture of the lives of married women in contrast to their husbands' lives:

Yes! We do 'tukara' a lot! Ei! 'Kafra [excuse my saying], if you get married right now, you'll never be free again. You go to the farm, you come back, then you come and go to the market, come back and put food on fire. Yes, we do a lot of 'tukara,' even more than men, because when a man comes back from the farm, he sits in 'akpasa' [lazy chair] and does not do anything, but you will come back and move about and do everything. The only freedom you have is the sleep you go to sleep. You will go to the farm, carry your baby at your back, you can't put the baby down, so the baby is at your back, and you're working, weeding, collecting firewood 'aaah...' [for a long time] like that. You carry the firewood on your head, the baby is at your back, you'll walk all the way back home, before you come and do more 'tukara' at home. You'll never be free, ooh. If you come back, if you don't have [older] children, then you go to the market, then you come back, you come back and cook, my daughter [addressing me], you yourself look ____ when you wake up, there you go again, you're never free! You just look at our work and see if you have any freedom on earth (int. 2:14-16).

Another woman talked in detail about the differences between the work loads of men and women:

- r: You see for women's problems, they are many. To be honest, our problems are many, especially if the person is a farmer. She will come back from the farm, she will cook, immediately she arrives, she will put water on fire for her husband, then she will pour that water for him first.
- i: Before we come to that, what happens when she goes to the farm?
- r: When she goes to the farm, she may carry her child at her back and walk all the way to the farm. When she gets to the farm, you put the child down, that is if the child agrees to be put down. If you have to plant cassava, you do that the whole day. When you close, because the sun is setting, you go and look for firewood. You will uproot some cassava for home, you will carry that on your head, with your baby at your back. The man will follow you holding only his cutlass under his armpit [both of us laughing]. He won't carry anything. Some husbands are so wicked they won't even help carry the baby. Some will help you with the baby, and when you are about to get to town, they give the baby back to you.

- i: Aha, why will they give the baby back to you when you get to the outskirts of the town?
- r: Because people will talk if they see him carrying the baby. Some of the men too can help you with the load, and when they are about to get to town, they give the load back to you.
- i Aha
- i: When you arrive, the man takes his bath and goes to drink palmwine or 'akpateshi' [local gin].. By the time he comes back, you are still in the dirt [have still not had your bath]. You prepare the meal, bathe all the children before you will get the chance to have your bath. It will be very late by the time you finish and go to bed. Sometimes when he returns drunk, then you people will quarrel. He will insult you, telling you that there is no salt in the soup you have prepared [laughing]... or the pepper is not hot! And maybe it's his tongue that is no longer functioning. You see, he'll quarrel with you right now. As for me I have seen these things before (int. 40:5-6).

The above descriptions of women's lives recurred throughout the interviews. While they were constantly working, the men had time to rest and engage in social activities such as meeting and drinking with their friends.

The women I spoke with acknowledged that men sometimes did more physically demanding work, yet the men had time to rest while they did not:

- i: So you're saying that we women we do a lot of 'tukara'?
- r: "Ho! Ho! Ho! [certainly!] More than even men. A man does a lot of hard work. If a man is weeding the cassava farm, and he's tired, he'll stop and relax. But for a woman there is no rest (int. 5:6).

The women explained that their work was "compulsory" because of its nature. Activities such as cleaning, collecting water, cooking, childcare, and the generation of income were not activities that could be postponed; they were necessary for the survival of families. A 39-

year-old woman who was the main bread-winner for her household regarded her roles as a wife, mother, farmer, and office worker as "compulsory":

- r: But a woman, there's no rest, if you're doing your housework, you can't say that your children's clothes are dirty but you won't wash them, you can't say that you're tired so you won't fetch water, it's "compulsory" [said in English], that you go for water. You can't say you're tired so you won't go to the market, or you won't cook. As for a woman's work, it's compulsory ____ no rest.
- i: You can't postpone your work ____ you can't say that your place is dirty so you won't sweep it.
- r: No, you can't say that. You can't say that I'm tired so I won't do this, or I'll postpone it. If you do it, it'll give you yourself illness, or your children, so it's compulsory, you have to do it (int. 5:5-6).

Women used the concept "tukara" to capture the nature of their daily work demands. They pointed to the challenges and hassles of making ends meet and taking care of their children. They talked about the unequal burden for women and men. They said women's work was essential and pointed out that in order for their families to survive, they were forced to engage in multiple work activities. The next section will demonstrate how some women went about juggling a variety of work activities.

Multiple Work Activities

One single mother explained to me how she juggled her work as a farmer and a trader:

So I specialize in making 'kenkey' [food prepared with fermented corn dough] and farming. When it's the farming season, I farm, I will go to farm today.

The next day I make kenkey, or I'll go to farm, come back and make the 'kenkey' (int. 71:2).

The nature of this woman's activity is not unique; many women engaged in similar multiple work activities. Some women, for instance, were both farmers and office workers and had to return from one job to go to the other.

One woman in my study explained that her work load had greatly increased since her husband had been laid off. Now she had to care financially and emotionally for her husband and their three children. Fulfilling all these responsibilities on a labourer's pay was not easy for her. To be able to cope, she had to take on other income generating activities in addition to her occupational and domestic roles. She explained how she juggled her various work activities during a typical day:

- r: I wake up sometimes at 3:30 in the morning, sometimes 4 ... If the children wake up before I do, I can't do my morning devotion. So when I wake up at 4, I can do my morning devotion, it takes me about one hour twenty minutes, it then be about 5. I'll make fire and put water on fire. When I make fire and if I have to cook, that is if there is no leftover food from yesterday, then I cook. Sometimes there's soup, so if I have to cook 'akple' [food prepared with corn meal], I cook it, and then I put water on fire for them. By this time, it may be about 6 o'clock, then I'll call them to come and have their bath. My eldest daughter can bath herself, the second one can also bath herself, but the youngest can't, so I bath him and then I go to the farm.
- i: You go to farm?
- r: Yes, every morning I go to farm.
- i: Hmm __ __ go ahead (laughing)
- r: So when I go to farm, I'll go and work "small" [for a while] and when it's 7:15 I'll come home and have my bath, eat and then come to work.
- i: Where is the farm?

- r: Around the house. It's not far from the house. If I don't do it like that we won't survive, because the pay is nothing. So I have to do all these before I come to work at 8 o'clock, the day that I'm late, then 8:15. And when I close at 5 as soon as I get home I start cooking the evening meal. And if I have to prepare some food for the following day too, sometimes I do that too in the evening before I fetch water and do everything else.
- i: You go to ____ the children are not old, so you fetch the water yourself?
- r: But now the two small girls, when I'm going they can carry small bowls and follow me.
- i: So it's you who fetches the water, cooks?
- r: Yes, I do everything. I don't have any maid, unless when my mother comes... Then by the time I close [from work] she prepares the soup for me. But if she's not there then I do everything.
- r: That's the day's work (int. 5:3-4).

Through her resourcefulness and hard work, this woman was able to provide cash and food for her family.

A seamstress who was also a trader went about her day in the following way:

Because my work is not no more lucrative, I now make porridge to sell. I wake up at 4 a.m. and make the porridge. I leave some in the house and then I carry some of it to a hospital close by for patients to buy. By 8 a.m., sometimes they buy all, sometimes it doesn't get finished. Even today they could not finish buying it, then I come to prepare and then I go to work (int. 12:2).

In addition to these activities, she farmed, kept livestock and looked for her own firewood, all in an effort to make a living.

A 36-year-old single mother of three, who was braiding another woman's hair during the interview talked about how she juggled her work activities as a mother, farmer, hair braider and stone cracker:

- i: Can you tell me how you go about your day?
- r: Sometimes when I wake up at 5:30, I wash the dishes, I see to the children and then they leave for school, and then I make lunch and leave it behind for them. I have a small farm. I go to the farm and work. On some days, I have a place [the quarries] where I go to crack stones. So when it's not 'market day' here or Torkor market day where I go to braid hair, I go to the quarries to crack stones.
- i: So you go to the market to braid hair?
- r: Yes, I have a space in the market.
- i: So you crack stones, you have a farm and you go to the market here or Torkor to braid hair?
- r: Yes (int. 13:2).

A 42-year-old professional teacher explained that in order for her family to make a living, she had to engage in various income earning activities. She woke up at about 3:30 a.m. to bake meat pies for sale in a secondary school near their home every morning before going to school. She was also a seamstress and further engaged in crafts such as crocheting for extra cash.

Another respondent was a janitor in one of the government establishments in Kpando. Her function was to wake up at dawn and clean the offices and the premises of the establishment before the workers came to work. She was also a hair dresser, and used her porch as a hair dressing salon. She also had a table in front of her house where she sold food items such as oranges, bananas and roasted peanuts. She juggled all of these activities with her household chores and childcare.

One theme that emerges forcefully from the above accounts is women's strength and resourcefulness. Their economic situations forced many women to engage in several different

income generating activities to either supplement or actually sustain their households. It is not farfetched to state that many women are the bedrock upon which their families rest. As the next section will show, most of the women I interviewed knew that their roles were indispensable to the survival of their households.

"We are both the Mother and the Father"

Many of the women I interviewed were heads of households and this had important implications for their workload and their health. Women became heads of households for many reasons. Some of them were married but had absentee husbands, thus they essentially lived with only their children. The husbands of some had jobs in different towns or cities and as a result could not live with them. In other cases the partner had travelled abroad. Other women were in polygynous marriages and since the man could not live with all of the women at the same time, some of the women were left alone to care for their own households. In these cases, the husband came in occasionally to visit his wife/wives and children. Other women were either widowed, separated or divorced from their partners or did not have permanent partners. Some women chose to be single.

As mentioned earlier, households headed by women are among the poorest because they usually contain fewer working adults and because women tend to earn less than men. This was apparent in my study, where many of the women I interviewed were the sole breadwinners for their households and most of their families lived in poverty, or, their

children were still in school and thus did not contribute to household income. One major problem these women faced as single parents was the "double" responsibilities and expectations they had to manage. As one woman pointed out, single parents become both "the mother and the father." In other words, they were forced to perform the roles they felt were supposed to be performed by men. For instance, in Ghana, disciplining children is usually the responsibility of fathers, and many women parenting alone explained how frustrating it was to discipline their children. All these problems, they pointed out, generated considerable strain and tension in their lives. A divorced woman explained how difficult life as a single parent was because she had to take care of everything:

If you are a woman and you live alone, it's a lot of 'tukara.' If you are alone and you don't have a helper, you are everything. Like me, nothing comes from anywhere, I have to see to everything myself, all the 'tukara' is on me. So that is a big problem for single women. It's a hard life for women who live alone (int. 66:3).

Many of the women further complained that their children's fathers had refused to help them look after the children thus leaving the entire burden of responsibility for their children on them. One woman explained how difficult life had become as she alone had to take care of her four children and two grandchildren on her meagre salary as cook:

A woman's life is difficult, it's difficult. And now, the men too have refused, they have refused to look after the children. So all that you're doing is not enough, you yourself, you see how the children are many ... And you the woman alone, you'll pay school fees, this time the school fees, you'll use 35,000 [school fees are paid each term, 35,000 Cedis represents about CAN\$49.00, equivalent to her monthly salary] to pay about three people's school fees. All of you will eat, the children will have to wear clothes, all

these look you the woman in the face [are your responsibility]. With that little money it's difficult. So life is difficult but well, we are surviving (int. 29:3).

As she was the sole breadwinner for the household, there was seldom enough money for her family. All the same, they were managing to make a living.

Another 36-year-old woman who had an absentee husband had this opinion about women's lives:

We women, we do a lot of 'tukara,' that is, like right now, the children I have now, their father is not here. He'll go for days without seeing the children. Sometimes when he comes, he comes in the morning when the children have gone to school, and ask 'how are the children?' That's all, but I have to see to it that they have taken their bath, they have eaten before they go to school. In the evening I have to see to it that they have had their bath and eaten before they go to bed. You see, so we women have a lot more 'tukara' than the men (int. 12:2-3).

In certain cases, women said that despite the fact that their husbands were at home with them they were still the main providers for their families. One woman said her husband had not had a job for several years, he had been farming, but the harvest had been poor because of the bad weather:

- i: And is he trying to get a job at all?
r: Yes, he is trying, but nowadays there are no jobs. He is farming, but the farming too, the rain is not normal. If the rain were normal then at least, this time we won't be buying food. He is trying to farm, but the rains are not coming. (int. 5:1-3)

Our conversation about her husband's job continued:

- i: Doesn't he get any money from the farm [through the sale of food stuffs]?
- r: No, since he lost his job he has been farming, but he has never brought anything from the farm and said 'take this and sell,' not even food for the home. Sometimes I have to buy more food, or I have to get them from my own farm (int. 5:8).

She continued that, in taking on all these responsibilities, she had started to view her husband as a son:

- r: So when it happened that way and my husband wasn't doing anything, I was getting fed up. And it was not raining too [so the crops were not growing well], and the children too... Now that I have taken him [her husband] as my first born, I can stand the problems _____
- i: Responsibilities?
- r: Yes, because when it's day break I have to see to it that he also eats, he takes his bath and everything. The children too the same. So I've taken it that he [her husband] is my eldest child, so we are there [that is how it is]. We are fine anyway.
- i: Mmmm
- r: But it's my wish that he'll get a job soon, that'll be good.... For the mean time I'm responsible for everything, the children's school fees. Now that Christmas is coming, I have to buy clothes for the children. (int. 5:7,8).

Although households headed by women experience financial and many other social disadvantages, a few women in my study said they chose to be on their own. There were others who were also considering it. They mentioned the fact that in living on their own they felt economically independent and were able to make their own decisions and choices. One woman talked about how "free" she felt living on her own. She said she did whatever she felt like doing, she ate what she felt like eating without anybody dictating to her. Another

respondent described the difference between being married and being single in the following manner:

Some women who have become responsible for their homes feel that they are better off living alone. Like me, I'm no longer with any man. I feel very free, and I'm looking better, I feel great! Those days when I was living with a man, I was always very thin, because of the 'tukara'. I was always worried... Now that I'm alone, when I get 100 Cedis [about \$CAN .14 cents], I know how to manage it. I know the money belongs to me (int. 6:5).

Other women living without men also mentioned that they were able to escape neglect, cheating, infidelity and other heartaches that they had suffered from their partners.

In sum, the women I interviewed talked about the work involved in maintaining their households. They pointed to the unequal burden of women's and men's work and how essential their work activities were. Most of the women engaged in a variety of different types of work to be able to maintain their families and the work load was even heavier for those women who were lone parents or who were solely responsible for their households. Women felt that their "tukura" was the source of their health problems.

THE HEALTH HAZARDS OF WOMEN'S DAILY WORK

As I pointed in the previous chapter, the women I interviewed reported suffering from health problems such as frequent headaches, fatigue, tiredness and pains in various parts of their bodies. Here, I will show aspects of their work that help to create these ailments that the women reported. In many instances the women linked their health problems to "tukara" and

exposure to certain conditions surrounding this. The connection between women's work and their health was thus a major theme in their constructions of their ill health. Most examples came from the informal sector. This is partly because few were employed in the formal sector and when they spoke about their work and health they mainly spoke about juggling different types of work, emphasizing their domestic labour and work in the informal sector.

One woman complained: "I walk too much that's why my legs are hurting." Another said: "I had to stop baking bread because the heat was too much for me...it was giving me illness." A fish monger also attributed the loss of her eyesight to the effect of the smoke from her smoker: "My eyesight is dimming because of too much smoke" (int. 45:1). One respondent explained that women were always on the move: "we go here, we go there, to see to it that everything is fine." As a result there was little or no time to rest, so she was always tired:

Just this dawn I was telling my husband that we women, if it's week-end and I don't come to work, I walk more than ten miles a day. I go to fetch water, come to pound palmnuts to make soup, go to farm, and do this and that. I walk more than ten miles a day, all these make me tired, the 'tukara' is too much (int. 5:5).

Caring for babies added to her tiredness:

If you have a baby, it's even worse. If you are pregnant, it's not difficult, when you stand up, you stand up with the pregnancy. But if you have a baby, you'll wake up and see to the child and everything, go and put her somewhere, before you yourself will come and get ready and go to work. It's a difficult job (int. 5:5).

She continued to argue that in addition to increasing their burden of work, childcare further reduced and interrupted their sleep:

There's too much 'tukara' in our lives, so to me, the children make your work at home increase even more. So if you have one or two children, stop, and when the children grow up, you can also get time to rest. If you give birth, you'll wake up more than three times to nurse your baby before morning, so your sleeping too is reduced, the housework increases, so from my own observation, the only way we can be a little bit free is when we limit the number of children we have. You see, now, my son is 5 years, very soon, I'll also be free (int. 5:5).

Women's indispensable, time-consuming and never-ending responsibilities were what my respondents said caused their fatigue, headaches and bodily pains. It was very difficult for women to get organized or have control over their lives due to the demanding nature of juggling domestic work, childcare and income-earning activities. A teacher made this comment:

With all my responsibilities I feel being a woman, especially a working woman is very difficult... You could just imagine how I get up very early in the morning [3:30 or 4:30 a.m.]. Instead of relaxing, I get up early, go about things and at the end of the day, I become exhausted, tired. So I feel, you become exhausted, sometimes you forget to even take good care of yourself, if you are not that type of woman. You go here, you go there, sometimes you won't even get the chance to cut your nails, you can't (int. 43:5).

One woman believed her bodily pains and tiredness were caused by her household chores. She said activities such as sweeping, fetching water and marketing were illness producing because of the physical exertion they involved:

r: Me, I do a lot of 'tukara,' I'm never free... my body aches, like my waist and my whole body will be paining me.

- i: What kind of 'tukara' do you do?
 r: I'll say, household chores. You see this house, it's a very big house, by the time you finish sweeping, you can't even stand up straight.
 i: Aha
 r: And fetching water too, go to the market to sell and all that, they make me tired (int. 52:4).

This particular woman lived in a house with a very large compound. It is a Ghanaian tradition for women to sweep their compounds every morning whether they are clean or dirty. Sweeping a compound as large as hers involved bending double for about one and a half hours.

Another woman explained that she experienced thigh and knee pains and tired easily when she washed her children's clothes. Most often washing is done in a bucket or a basin and requires one to bend down in the process. She felt she was no longer strong enough to be doing strenuous activities such as washing as a result of doing too much "tukara":

I get tired after working for just some few minutes, I get tired, I do a lot of 'tukara.' Like this morning when I woke up and was washing the children's clothes, I said 'Ah! My knee, thigh,' you see, so I'm not strong. There are some people who will wash all these things but will not feel anything, but because of too much 'tukara,' it is affecting my thigh and my knee (int. 12:11).

Before I arrived in the home of one of my respondents, I saw her returning home carrying a very large basin of fish on her head. In the course of the interview, she complained that her neck and back pains were caused by the heavy loads that she carried from the riverside everyday:

- r: My neck and my back pains me...
- i: I see, why do you think those places pain you?
- r: Walking and 'tukara,' carrying heavy loads, from the river side to Torkor station. Sometimes they can be so heavy, and I don't get anybody to help me bring it, so I have to carry it myself.
- i: I saw you carrying one today.
- r: Aha, you saw me?
- i: Yes.
- r: I told the driver to bring me home, but he refused. So I had to carry it from the road side to the house. You'll be so tired, you won't even have the energy to eat (int. 45:6-7).

Another woman explained that carrying heavy loads such as pots of palmwine and firewood from the farms made her body ache. The aches and pains were so severe that she found it difficult to carry her baby:

Carrying the palmwine from the woods too, and the firewood too, gives me chest and back pains... They are heavy, and I have to carry them over long distances from the bush ... Even right now that I'm sitting here, it's paining me. So I can't even carry my baby at my back too much (int. 51:6).

She continued to explain that many women, including her mother complained of aches and pains. She said they experienced pains in their waists, sides and shoulders because they bent down for long periods of time when working on their farms. She attributed shoulder pains, for instance, to the strain involved in cutting firewood especially with a machete.

A woman who earned money by cracking stones for builders explained that the process of looking for stones and collecting them into heaps before cracking them was energy draining. She usually had to walk for long distances collecting stones to bring to the

quarry. She believed that carrying basins of stones and the exertion involved in cracking them (sometimes with a bigger stone or a hammer) were the main causes of her chest pains:

- r: I have started having chest pains, so I am trying to reduce the amount of stones I crack.
- i: Why do you think you're having the chest pains?
- r: The stones. Those who employ us take us to a site and show us the amount of stone we have to crack. We then have to collect the stones from the site to another place for cracking.
- i: Aha
- r: The process is difficult. I carry and crack them alone, it's a lot of 'tukara.' I think that's why I'm having the chest pains (int. 13:2).

An elderly woman also attributed her headaches, bodily pains, tiredness and general weakness to her farming and trading activities. After doing her household chores this woman had to walk for about an hour to get to her farm and then worked under the hot sun for the whole day. On market days, she returned from the farm with foodstuffs and firewood to sell in the market for cash:

The work we do _____ they are many. You can wake up, sweep, go to fetch water, go to farm, and the farm is far. It takes me one hour to get to the farm, and when you go, you work the whole day under the sun ... And on market days, I try to go to the farm to get some foodstuff, like cassava, firewood and others for sale (int. 15:1).

A young woman who brewed "solom" (the local beer) for sale talked about the demands of her work. She had to walk several kilometres into the bush to look for firewood. She then had to walk from her village to town to look for water, because there was no tap in her village. Since the process of brewing the beer involves a lot of water, her journey for

water collection had to be made several times. To her, it was the physical exertion involved in these work activities that caused her bodily pains and weight loss:

- i: Why do you think you are losing weight?
 r: The work, the 'tukara' is too much.
 i: What about the body pains?
 r: It's because of my work. I carry heavy loads too much. If you see the bowl I carry to fetch water?
 i: Aha
 r: Do you know 'kpolu' [a huge wide enamel bowl]?
 i: Yes.
 r: Yes, that's what I take to carry water, with this baby at my back, because sometimes he will be crying, so I can't leave him behind.
 i: And you live far away from town?
 r: Yes, sometimes when water is scarce we have to go all the way to Tech. [Kpando Technical school, about 4-5 kilometres from where she lives] with the baby at my back. By the time I come back once, my waist, my back will be paining me. That's why I have bodily pains. Brewing beer involves a lot of 'tukara.' (int. 65:6).

Brewing beer also requires intense heat and it was necessary for this woman to come into contact with this heat. To her, this was the cause of the pain she felt in her body:

Yes! You are always in the heat! Heat! Your whole body will be hot....By the time you finish brewing, your whole body will be paining you, my back! my head! (int. 65:2).

Talking about the cause of her aches and pains, a woman who traded in corn also referred to the nature of her work. She explained that acquiring bags of corn for sale was a strenuous job. It involved travelling in a canoe for several miles to farming villages. When the bags of corn were brought to the shore, she had to scramble and claim ownership of the

number of bags she was interested in buying. These bags of corn would then have to be packed into canoes back to Kpando for sale.

If you don't struggle, you won't get corn, so you have to fight hard. You have to pull bags of corn yourself ... a whole bag of corn [a bag of corn weighs about 50 kilos]. You have to struggle [with the other traders], pull the bags yourself and claim ownership ... so that's what I think is the cause [of the bodily pains] (int. 39:9).

Another trader explained that "tukara" was the cause of her dizziness and the feeling of heaviness in her body. Her business involved travelling to the city to buy items such as saucepans and plates. She sold them on credit travelling from one house to the next. She then had to visit her creditors every day, collecting her money in small amounts until she had enough to go on another trip. This method of trading involved a lot of walking. It also involved a lot of tension and stress because some people refused to pay their debts and this resulted in quarrels. Her job thus left her with little time for rest. She said even when she got the opportunity to relax, her husband criticized her for being idle:

- i: What did you think caused the dizziness?
 r: I think it's because of the 'tukara,' because I have observed that I am never free. Even this, I am just back from town, I have to wash these things and then start the evening meal. So you'll see that the 'tukara' are many. And some of us, our husbands get angry quickly, so I can't even rest. As for a nap in the afternoon, I don't get the chance to nap in the afternoon.
 i: But it's good for us.
 r: It's good, but you can't rest. If you should attempt to rest, then you'll be regarded as a lazy person. And you have to prepare the meals too on time, you understand?
 i: Then you should be cooking some of the food ahead of time, so that you can get sometime to rest.

- r: [laughing], yes, I sometimes try.
 i: But you know, they want it hot.
 r: Yes! It's a problem. They said a man said he did not see his wife cooking the food on fire and because of that he won't eat it! The food is cold, so he won't eat (int. 14:7).

As pointed out in Chapter 3, most Ghanaians prefer food which is freshly prepared every day.

One of the main staple foods, fufu, must be prepared every day since it cannot be preserved².

Another respondent, a single mother, said she was suffering from a stomach ulcer because the nature of her business did not give her the chance to eat properly:

Because I trade I'm always on the move. I don't eat properly, and I don't eat on time ... I can go for several hours without eating, so now I have ulcer (int. 67:6).

The same respondent was suffering from hypertension too. She believed that this illness was caused in part by her hassles as a single mother who was struggling very hard to take care of her children:

Yes, I do a lot of hard work to look after the children, I suffer a lot. I know that my illness was caused by 'tukara.' Because I am responsible for the children's school fees, I have to make "shitor" [a kind of gravy prepared with dry fish meat and vegetables] and buy "gari" [powdered dry grated cassava] and all that for them to take along to school. All these are my responsibility, that is why I said I was suffering. To tell the truth, day and night I'm on my way to one of these markets, Abotiasse, Kwamekrom, Kpando, Torkor markets. I'm always on the move, I don't have the money too, so I have to go for the goods on credit, and try very hard to sell the items, that is the only way that I can get more items to sell tomorrow. So all these 'tukara' has caused my 'plenty blood' [high blood pressure] (int. 66:5).

She claimed that her health had deteriorated when the goods she had gone to buy from Togo, a neighbouring country, were seized and she herself was thrown into jail by the border guards and customs officials on her way back to Ghana:

They put me in jail at Barracks at Ho [capital town of the Volta Region]. When I came back I 'hanu' [worried, lamented]. All my goods were lost, I lost my money ... I bought cigarettes, batteries, sugar. All gone... Under those conditions, when I came back I fell seriously ill and I have been ill since then. Initially when I came back I was just behaving like a woman who has had a broken heart (int. 66:6).

Similarly, an elderly woman, also suffering from hypertension believed that the cumulative effects of the work activities she engaged in when she was younger had led to her present state of ill health:

The work was too much for my blood ... it was difficult, but I forced myself to do it ... And I came to realize that I was tired, because things that I should not have done too, I did, so all these things are worrying me now _____. Now my whole body is paining me, every part of my body is paining me, sometimes I won't get out of this house for three days (int. 35:1).

Many women believed that their fevers were also caused by "tukara." Some women said they suffered fevers because they spent too much time under the sun working. A woman explained that she always suffered from a fever when she worked very hard: "When I do the 'tukara' like that, then fever catches me. I always get fever" (int. 14:7). Another woman, a trader directly pointed out: " 'tukara' will catch me, I get fever" (int. 40:12). To this woman the "tukara" that gave her the fever was her trading activity. She had to travel several kilometres to the city and then walk long distances to different communities buying coconut

oil for sale in Kpando. She said the process was so tedious and difficult that she often suffered from bodily pains and fevers at the end of each journey:

So you have to walk to all these places, and then I have to pack all the containers of oil at one junction, for the truck to come and collect them, you see. So the amount of walking alone that you do, is 'tukara,' By the time you come back, your whole body will be aching, you'll be so tired.... Sometimes if you don't get transport, you'll remain there, you'll be hungry... Sometimes you won't even get water to buy and drink at the junction, you'll be there without water and food.... So that's my 'tukara.' Sometimes I get fever as a result of all these... Sometimes when I come back like this, I can't even stand up, if I attempt it, I'll feel weak, yes, the sole of my feet will be paining me like I have sores there because I have walked for so long. I will be tired (int.40:12-13).

The situation was not much different for those working in the formal sector. A woman who worked as a cook for one of the secondary schools in Kpando complained about how strenuous and physically demanding the work was and how it led to health problems:

The work is so difficult that it gives us illness. Sometimes if you go to work from the morning, you can be on your feet, working throughout the day, until you close. All these have resulted in pains in our knees, legs and joints. Also, when you go to work like this, and the work requires sitting down, you will continue to sit down until you close. So these days when we sit down we feel pains in our thighs and the muscles under our thighs (int. 29:1).

She further complained that the pot in which they cooked "banku" (the daily staple, a very thick porridge made with corn flour) was too big and this made stirring the food extremely difficult. Yet despite the fact their work produced aches and pains, the women had no other choice than to continue doing the job:

This big enamel bowl is size 50! And only two of us are supposed to stir the 'banku.' After that you have to be on your feet to mould all that 'banku' into

small balls until it gets finished in the bowl. All these are 'tukara,' you fall sick. But the following day it will not even be 5 [a.m.], you are on your way back to work. It's a lot of 'tukara' but because of poverty, we are managing (int. 29:1-2).

A trader made a similar comment concerning her work. She said she was forced to continue working even when she felt very tired, because she did not experience the kind of security that office workers usually enjoyed:

No, if you are not on a monthly income, then you have no choice, you have to work hard, there's no pension, there's no back pay [an accumulated worker's benefit], I have not gone to school, so I'm not doing any 'white man's work' [office work] (int. 40:13).

In spite of the demanding nature of women's jobs, it appears that these are normally the only avenues open to women to earn cash. They face a predicament in which they must continue to do such jobs throughout their working lives, until their health can no longer permit them.

"Tukara," or the various hassles in women's lives, was thus identified as the cause of many ailments that women experienced. Their health was inextricably linked to their everyday work. Women claimed that the combination of heavy labour, repetitive and never-ending household chores and little rest made them susceptible to different types of illnesses and ailments. They experienced headaches, fatigue, bodily pains, dizziness, hypertension and many other health problems as a result of the conditions under which they worked. For the women I interviewed, life as women was in itself illness-producing. This conviction would seem to inform the ways they constructed their health.

THE EFFECTS OF FINANCIAL PROBLEMS ON WOMEN'S HEALTH

Financial problems are the most important. Even right now that you see me here, I've come to borrow money from my uncle. Money is a big problem (int. 25:5).

Almost all of my respondents would agree that "financial problems are the most important" and many faced a precarious financial situation. Even with the number and variety of work activities they sustained, most women found it difficult to make a decent living. Almost all of them complained about having insufficient money or having to manage with little money. They also identified a relationship between their financial situation and their health. Many of the women I interviewed explained that financial problems were one of the main reasons why they "worry" or "think too much" and why they had to work even more. Their poor financial situation made some of them cry frequently. Many of them also had headaches, had lost weight and found it difficult to sleep. Lack of money also prevented them from seeking health care when they were experiencing health problems.

One woman, a bar keeper, explained that money problems created uncertainties in her life and was a source of worry and tension for her. Her financial situation made it impossible for her to prepare for emergencies such as illness or sudden death:

Most of the time as a woman, if you don't have money, it's a big worry, because money matters are worrying. Sometimes if people don't buy the gin, then things become very hard. And illness too ___ you'll be there and unexpectedly one of us will just fall sick. It's a big problem. Or your loved one will just die. All these things are worrying (int.51:3).

Lack of financial control over their lives was thus mental torture for many women.

Things were difficult also for women whose husbands controlled the income from their joint income earning activities. One woman, for instance, explained that she helped her husband to brew "akpeteshi" (local gin) for sale. However, her husband did not pay her or share any money with her. She explained that the uncertainties created by her lack of money created stresses and strains in her life. The result was that she cried frequently:

Hmm, money problems ___ especially, because despite the fact that I work very hard for this man [her husband], he doesn't like giving me money. And sometimes I need money, so when it happens that way, I cry, I worry (int. 51:4).

She felt her headaches were caused by worries and her frequent crying, as was her weight loss. She continued to explain that due to her financial difficulties she had yet another burden - she was unable to care for her aging mother:

As for 'dzitsitsi' [worry], it's money that causes it, because right now, my mother is old, and I need to start looking after her, and I don't have money, I don't have any money of my own, so I can't say, 'mother take this money.' That's why I don't put on weight. I worry too much (int. 51:4-5).

I asked why she did not have her own job so that she would be able to earn her own income. She explained that she had tried her hand at trading in different food items but without success. She could not invest enough time in it because her children were many and were not old enough to be left on their own:

I tried to sell cassava dough, but I was not making any profit as such, especially if somebody buys on credit and doesn't pay back on time, you start losing. And I have many children [7 in all, 5 of her own and 2 of her

husband's], so it wasn't worth it. I have tried to sell different things, but none has really worked . My mother sells 'kenkey' [a type of food made from corn flour] but there's a lot of 'tukara' involved, I can't cook it alone. By the time I finish seeing to the children, cook the 'kenkey,' go around the community to sell it, I can't do it. If you have children like mine... they are not old, it's not easy (int. 51:5).

The combination of childcare and other household responsibilities thus prevented this woman from doing her own job. The result was that she had become totally dependent on her husband. She felt this situation was not healthy for her.

Another woman said that her financial woes were intensified when her husband died. It was expected by tradition that her husband's cousin would become her new husband and look after her and the children, but he refused to do so. She thus became solely responsible for her children, she explained that the process of finding ways and means of taking care of the children was giving her sleepless nights, bodily pains and fever:

He didn't look after the children for me ... so I had to look after the children myself ... I will carry food for about 6 miles ___ to cook for them ... I worry about the children, asking, 'What kind of work can I do to look after these children, so that they can go to school' I worry about it ... When I work too I'm not successful, I think a lot, now that I'm here, I have fever in my body. My whole body will become very hot, very hot! In the night I can't sleep, I'll be turning in my bed. I have observed that thinking is bringing me all these illnesses (int. 64:2-3).

Another woman who fended for her household alone complained that her husband was insisting on a fourth child. To her, another child would mean an additional mouth to feed:

- i: Are you going to have more [children]?
- r: The three is enough, but my husband is not agreeing, because at the beginning when he married me, we agreed that we shall have four children.
- i: Aha
- r: But the way things are hard now, I don't think it's a good idea. That's why I'm saying three is enough (int. 5:1).

She explained that she was responsible for providing everything for the household because her husband's farming activities did not bring any food or money home:

- r: So now he does not have a job, and he's in the house, and the children too are there. School fees, school uniform, food, soap, everything, his own responsibility is now mine, he's become my first born now.
- i: I see.
- r: And you're not doing any work, so all the burden is on me, and he is putting pressure on me.... He won't understand. As for me the pressure and the financial burden [said in English], that's why I say three [children] is okay (int. 5:1).

She pointed out that she was "always thinking" and found it hard to sleep because of the difficulties involved in maintaining the household alone. She said there were even days when she did not have any money at all to feed her children:

You can't sleep, it happens to all women, because like me, I have three children and sometimes, common 10 Cedis [an amount as low as 10 Cedis, an equivalent of about \$CAN .01 cents], I won't have at home. Tomorrow by all means I have to give the children money to take to school, I know that, but what can I do? Sometimes, you have corn, but you cannot roast corn for the children to chew, so you'll be thinking, 'Jesus, when I wake up tomorrow, where am I going? What am I going to do?' (int. 5:11-12).

This woman's situation as the wife of an unemployed man and thus singlehandedly responsible for upkeep of the household, had translated into persistent "thinking too much" and sleeplessness.

The women who were employed in the formal sector were also concerned about not earning enough to care for their families. Many pointed out that they were working, but they did not earn sufficient to make a decent living. "Whatever you get, it goes into the cooking pot" (int. 36:10) [in other words all earnings are spent on food and other basic needs for the household]. They believed that jobs in the formal sector would provide them with a steady predictable income and improve the conditions in their households, yet in order to make enough money to care for their children, they had to struggle and engage in many different types of work. As pointed out earlier, most of them had young children who were unable to contribute financially to the maintenance of the household. In many cases where women were living alone, the whole burden of taking care of the household fell directly on their shoulders.

One woman talked about how necessary it became for her to leave her husband behind in the village to enter the fish trade once they realized they could no longer survive on the proceeds from their farm:

Because of the welfare of the children I had to leave. My husband is a farmer, but the harvest wasn't good. There's not enough for us to eat. I have to work and buy corn for the house before we eat... I would have wished to continue living with him, I was not happy when I left him, but that is not possible. If the two of us go to the farm, we will perish (int. 45:3).

Economic necessity, then, is breaking up some Ghanaian families. In order for her family to survive, this woman decided to leave her village and her husband and work as a fishmonger in town. Her choices were not without censure. The methods and schedule of her trading had prevented her from attending church services on Sunday and her friends had criticized her for this. She pointed out that she had no recourse other than to continue to trade in that manner:

- r: Last Sunday somebody told me something that bothered me a lot.
 i: Aha
 r: I was rebuked for not coming to church, but what can I do? You see this fish [pointing to the fish in the basket]?
 i: Aha
 r: Some people have tied money on their loin cloth, full, like 100,000 [about CAN \$140]. They go to Torkor [a fishing village] and buy in bulk. So on Sunday, she [rich market women] won't go, but I don't have that kind of money, so I go, with maybe my 2,000 Cedis [about \$CAN \$3], when I buy about 4,000 Cedis [about CAN \$6], I pay 2,000 and get the rest on credit. Then when I finish selling it, I send the rest of the money to the creditor. I would have liked to go to church on Sunday, but I can't. So when I heard that, I told them that it wasn't my wish to stop coming to church, but what can I do? So these are the 'tukara' in our lives. If I don't do it that way, it will not be good, we won't survive. And if you ask for loan now, the richer market women will sell it to you, the interest will be too much (int. 45:4).

Although it bothered her that she was being criticized for not attending church, this woman had the will to withstand the criticism, since she felt that her trade was the only means by which she could make a living.

The financial situation of women deteriorated when they were unemployed. To one of my respondents, the stressful situation of not having a job worsened her health:

- r: You yourself look, it's been quite a while, a mature woman like me, I wake up everyday and just stretch my legs down [ie. sit idle]. It's hard, hmm..
- i: What effect does all these have on you?
- r: Thinking. Always thinking, these are things that bring the ill health [laughing]. When you are thinking too much, then fever also enters (int. 67:4 and 6).

Some women pointed to the fact that not having a job or one that did not pay enough money could also produce specific illnesses. One woman for instance indicated that the "thinking" and the "worry" that resulted from a profitless business could lead to high blood pressure:

Some people too, if their job is not successful, all the time, you are working hard but you're not making any profit, you'll worry, you can't sleep. Every time 'your heart is hot' [she becomes stressed out] you can get BP [blood pressure] (int. 13:7).

Lack of money was also identified as one of the causes of sleeplessness. An unemployed woman talked about how she had frequent headaches and grew thinner as a result of thinking too much about her financial problems. She mentioned that Christmas was fast approaching, but so far she had not even been able to buy her children "obroni wawu" (literally, "a dead white man," meaning second hand clothes). This was a source of worry and confusion for her:

Now Christmas is coming. We live in a big house, everybody is making preparations for the children, but it's only me who has never bought even

'obroni wawu.' As for me I'm celebrating it already. I can even take this [pointing to her dress] to church, so as for mine it's not a problem. It's the children I worry about, because there's nobody I can talk to for help, so I 'hanu' [worry] a lot. I think a lot... Sometimes when I think for a long time I my head and my whole person become 'basaa' [mixed up or confused], you won't know exactly where you are [she becomes absent minded] (int. 7:6-7).

The reality of women's lives was also forcing them to become even more resourceful, since that is the only way their families could survive. One woman recounted how she went about managing the little money she had:

Now, sometimes, you will be staying with a man, you'll see that you have 'tukara,' the 'chop money' [money for maintaining the household] he is going to give you will not be sufficient, so you have to pass somewhere and look for more money. If you have food, when they give you some small money, then you can use that to buy fish. Like me I like farming, when I wake up, on the days that I won't go to work, I go to the farm, I'll go and work the whole day before I come back home. There are many things, like firewood, if I have to buy charcoal, I can't afford it, it's too expensive. I use it, but I use firewood too, so that the money I have can take me further. I rear chickens and goats, so when I'm in need of some money, I can catch one of my goats and sell, so that nobody hears of my poverty. So we women, we suffer (int. 12:3).

Poverty or inadequate financial resources were a great source of distress for most of the women I interviewed. Many of them said financial stress was the main cause of their worry and "thinking too much." They also mentioned that financial problems made them think so deeply that they forgot where they were and what they were doing. Sometimes they could be so deep in thought that they were not aware of the fact that they had wandered into the middle of a busy road. Also, because they were so deep in thought and unaware of their surroundings, they were startled when they were called. One of my respondents explained

that worry about where to get the next meal for one's family was a source of mental distress for women and their behaviour made people think they had some sort of mental illness:

All these responsibilities make them [women] think too much, 'where am I going to get food for these children today? What are they going to eat today?' You see that you are alone but you are talking to yourself. Then you'll say, 'Let me go to the farm and look for some food,' and then you carry your bowl on your head, and while on the way to the farm you are talking, 'ah! Well, let me hurry up and come back before they come back from school.' Somebody passes by you and looks back at you thinking that you're mad, but it's not madness, you are only thinking. Sometimes you don't even know that you are talking loudly, but someone who overhears you will say 'Ei! Is this woman tying one yam [behaving abnormally]?' (int. 6:10).

In addition to the health consequences women experienced because of their financial stress, lack of money also made it difficult for women to obtain medical care when they were ill. On many occasions I asked women who were seriously ill why they did not seek medical help. The most frequent answer given was their lack of money. A widow who had been ill for several months before my arrival complained that she was still experiencing some of the symptoms of her illness but could not do anything about it because she did not have enough money to pay for a medical checkup. According to her, she had no choice other than to try and forget about the illness and continue with her life of pain:

Yes, but I have tried to forget about that [the illness]. I feel it [the pain], but I still go to the farm with it. Yes, I go with it, if I sit down too it's not good, so I farm, because I don't have money to go to the hospital and say this is it, so look at it for me... Hmmmm, the thinking and the illness oooh, where can I get money? I wish I can go to the hospital again for treatment ____ but aaah since there's no money, how am I going to cure my illness? So that is how we are existing.. (int. 2:23-24).

Since health care has become more expensive with the Structural Adjustment Programme (SAP), there is the likelihood that many more women like this widow will go on with their lives with little or no medical attention.

Unemployment, financial problems and sometimes abject poverty were common themes in women's explanations of ill health. Many of the women I interviewed worried about how they were going to feed and clothe their children, pay their children's school fees, or pay for their health care when they fell ill. They were aware that poor diets and unhygienic conditions made them ill. However, they pointed out that it was impossible for them to live healthy lives without adequate finances. To them, lack of money affected their health in a variety of ways. Poverty or having to manage with little money was stressful enough to have serious effects on their physical and mental health.

SUMMARY AND CONCLUSION

Women recognized that several aspects of their lives had negative effects on their health. They told me that the nature of their work, added to their poor economic situation, was detrimental to their mental and physical health. They complained about thinking and worrying too much, fatigue, frequent headaches, fevers, and pains in their body and they recognized that the content and characteristics of their work and their financial situation were among the major sources of their ill health. The struggles of most women revolved around procuring the most basic necessities of life such as food, fuel and water for their households.

These, together with the burden of housework, childcare and subsistence food production are aspects of social reproduction which they linked, in particular, with physical health problems. They also worried about their capacity to maintain their families given the financial insecurity that marked the lives of so many women. They had to intensify their income generating activities and these also contributed to their physical and mental health problems.

These problems can also be understood in the broader context of the Structural Adjustment Policy (SAP) in Ghana which has worsened the economic and social status of women. The present economic situation has forced women to adopt new strategies for survival such as engaging in multiple work activities leaving them with even less time to rest. Cutbacks in public expenditure have adversely affected women who are both the producers and consumers of social facilities. Women in Ghana have had to shoulder the heaviest burden of poverty and the stress resulting from these policies.

Women's heavy workloads and the economic problems they face are also exacerbated by, and in turn help to create conflicts in their family, particularly in their relationships with men. They saw such strained relationships as another source of the health problems they experienced. These are the focus of the following chapter.

NOTES

1. This term is likely a derivative of terms used in the Mole Dagbani languages of the northern region of Ghana. Etymologically, "tukara" is a combination of two Dagabani words. The words "tuma," "tung," or "tong" are often used interchangeably to refer to "work" or "errand." To qualify or describe the nature of a particular kind of work or errand. The Mole Dagbani combine these words with a range of adjectives. The Mole Dagbani use terms such as "tunkpala" (hard or difficult work), "tunkpala" (useless work) or "tunkara" (work that is energetically demanding or which the doer is unprepared for, but has been compelled to do by others, or is performed under difficult and usually unforeseen circumstances). The term "tukara" presently common among the Ewe of the Southern region of Ghana might therefore have been adopted from the latter Mole Dagbani word. In a generic sense it is used to describe hard and sometimes unrewarding and meaningless work, or the hassles that people experience in life (Personal Communication: Kwabong Danabang, 1996).
2. "Fufu" is prepared with cassava, plantain, yam or cocoyam. These root crops are cooked and pounded into a thick paste in a mortar with a pestle.

CHAPTER 7: RELATIONSHIP PROBLEMS

This chapter continues my analysis of the ways in which the women I interviewed constructed their health. I show how these women made a connection between their social relationships and their health. Many women complained that their relationships with their partners, co-wives, mothers-in-law, children and other relatives sometimes adversely affected their well-being. These problems were not limited to women with partners, but extended to those who were single, separated and divorced as well, though they were more often concerned about lack of support and companionship. Women argued that relationships were stressful and made them "worry too much" and "think too much," they were either unhappy or depressed much of the time, and as some of them indicated, a woman's "heart is never free." Some women also said they were absentminded and found it difficult to sleep. Some of them admitted exhibiting "abnormal" behaviours such as talking to themselves or throwing their hands into the air as a result of their numerous problems. They felt that their greatest sources of stress and tension emanated from their relationships with their partners; relationship with men were central yet problematic. Even though women feared that their husbands might leave them, married life was characterized by many conflicts.

RELATIONSHIPS WITH MEN

A theme that emerged in the women's accounts was the insecurity they experienced in their relationships with their partners. They explained that their husbands could divorce or abandon them for flimsy reasons; some women expressed fear of this possibility. For instance, not serving one's husband on time, serving the same kind of food every day, serving cold food or food without enough salt or pepper were all reasons for a woman to be physically or verbally abused, divorced or abandoned by her husband. Women pointed out that the inability to give birth to male children was another reason husbands divorced or abandoned their wives. Some women were abandoned for no apparent reason. One woman said her husband "left us just like that" (int 67: 3) without giving her and her children any reason for doing so. Others said that after they had helped their husbands to become established financially, the men abandoned them, placing them in a "no parking zone" (a local expression describing a situation in which women are abandoned by their husbands for other women). For the most part women's impressions about marriage tended to be negative. In the following quote a woman captures the general perception many women had about married life:

Ei! As for marriage, it's hard oooh _____ it's hard because some of the men, they don't have pity for women, you will continue to suffer like that. When it gets to a certain stage that things become a little better for the man, he'll go in for another woman and leave you. You the woman you'll just be there, no progress in your life (int. 47:2).

Women were quick to stress that their relationship problems caused them ill health. For many of them, marriage was an institution which exposed women to insecurities and uncertainties in life, and to conditions which produced some of the illnesses they experienced. One respondent believed that the break up of a marriage could lead to a woman worrying and “thinking too much”:

Or you have loved someone and stayed with him for sometime and then he decides to leave you. You'll 'tsidzi' [worry] and 'hanu' [lament], and all these can make you fall ill (int. 13:7).

This particular woman believed that she had once suffered from hypertension because of the behaviour of her former partner. She went on to recount how she was abandoned by her partner immediately after her second baby was born:

It was when I gave birth to my second daughter. To be honest, I believed strongly that it was caused by 'taamebubu sugbor' [thinking too much]. The relationship between me and her father was very bad, there was a lot of 'tukara' [problems/ misunderstandings] between us. So I became very very worried. So one night I was asleep, one of my sisters who came to live with me when I gave birth said she observed me struggling. The only thing I remembered was that I was having a very severe headache. I could not even put my head on my pillow, so I sat up and was holding my head, then she saw that - by then my daughter was about two weeks - then she saw that I was struggling, and then I started foaming at the mouth. So she carried my daughter and rushed off to call my aunties. By the time they came back, my face had cleared up. So they told me what happened; I didn't believe them. So when I went to the hospital and they took my blood pressure, it was very high. I was advised by my midwife that if I didn't stop worrying, then I'll die. I just left my brains [stopped worrying], so it does not worry me like that. It is usually high, but not so high (int. 13:6).

Another respondent believed that some women suffered from mental illness because of the shock of being abandoned by their husbands:

And the man will move out, leave you and go and stay with his girlfriend. You the wife, the man will not care whether you and the children have eaten or not. So all these things give you mental illness (int. 19:9).

For one woman, failed marriages and bad marriages were developing into a chronic pattern in her life. She said she had already had three failed marriages and was in a bad one presently. This made her worry constantly and was affecting her physical and mental health. She explained that she always suffered from severe headaches, bodily pains and stomachaches. She also experienced difficulty sleeping:

Yes, it worries me a lot, it worries me a lot. If you're not patient, this makes many women worry, and if you don't take care, you can pass through that and die because you're always worried, your heart is never free ... Because you see right now, when I worry or think too much, I get this severe headache. When my head is aching like that, then my neck also starts paining me, then I start experiencing the pain at my back, then my stomach, and this will continue to pain me for a long time, before I feel better. Because I have thought about the issue too much, my heart will not be free. So when I lie down and sleep and wake up like that around 12 midnight, I won't sleep again until day breaks (int. 50:5).

This woman thought that she might soon stop seeing men altogether and instead make an effort to be on her own: "it is not necessary for me to be suffering or worrying about wanting to be with a man by all means." She took care of her children alone so she felt it made no difference whether she was married or remained single, "because all the children are my burden, all of them."

It is understandable then, that the behaviour of their partners caused them to worry and “think a lot”. One respondent explained that Kpando women often become very concerned when all of a sudden their husbands begin to behave rudely towards them:

Like you can be with your husband, after a while, you'll realize that his attitude towards you will start changing, the way he talks to you will change. Like if you ask him for something and he doesn't have it, you'll expect him to give you a polite explanation, but no, and this makes you think if our husbands have other women in town, or what? These do not make our 'heart feel free' (int. 15:4).

The respondent quoted above believed that women could begin to behave in unusual ways as a result of thinking or worrying too much about their husbands' behaviour:

We women worry a lot about our husbands... I feel that if you worry too much, you are always in pain. The least thing that happens to you will become a big illness for you. And if you don't relax, you'll turn into something else... You will not be yourself, you'll just be there, because your thoughts are many, you see, your thoughts are more than what God has made into your head, because you have come to add more to your thoughts. So if you don't take care, you'll start 'tying one yam' [behaving unusually] (int. 15:4-5).

In Ghanaian society it is considered ideal for a woman to marry, live happily with her husband, give birth to children and thereby contribute to the continuity of society. But for the women I interviewed, marriage did not always guarantee the happiness which was crucial for their well-being. On the contrary, they believed that their marital relationships detracted from their mental well-being as the threat that their husbands might leave them often made them think and worry too much. These problems became even more intense among the

women who were abandoned. Indeed, the fear of being deserted meant women might tolerate abuse and unhappiness in their marriage.

Physical and Verbal Abuse

Although abuse by partners was not a major theme in women's conversations, some of the women I spoke with did complain that their husbands physically or verbally abused them or did not talk to them. A young woman mentioned that physical abuse by partners was quite common; she also noted that many women were unwilling to talk about it. She recounted how she had miscarried after she was severely beaten by her husband, a law enforcement agent:

He beat me and stumped his feet on me. By then I was six months pregnant, and I got very sick and was rushed to the hospital...I lost the baby... Oh! He beats me, he beats me very well [laughing]. People won't tell you, they beat us (int. 19:3).

She said further that she had been physically abused not only by her husband but also by her husband's nephew who was living with them.

A 26-year-old woman also told me how her lover beat her and dislocated her arm when she complained about his infidelity:

One week before Christmas, he beat me. My arm got dislocated so they had to tie it with some local herbs for me. So even right now, when I do some hard work, I still feel some pain (int. 46:3).

Abuse was not only physical in nature. It also included forms of mental abuse, such as ignoring women, not communicating, discounting their concerns and insulting them. Some women complained that their husbands did not communicate with them despite the fact that they lived under the same roof. One respondent pointed out that she found it very difficult to approach her husband with a problem and this made her very unhappy:

Yes, we don't converse, we'll just be there. Even how to approach him is a problem; I can't approach him. What bothers me most is that we are two at home, in the evening, we can converse and make plans, but that doesn't happen. For example, when I am worried, or I have a problem, and I approach him, the only thing he will say is I'm worrying him too much, and this worries me a lot. And because of that I'm not happy. Despite the fact that he tries to provide for my needs, we don't communicate. So that is one of my problems (int. 55:3).

In response to my question about whether she had ever asked her husband why he did not talk with her, the woman said her husband claimed to be by nature a quiet person, someone who did not like to talk. She felt that he lied; she said she knew very well that he was a good talker.

Another respondent said that what worried her most was the fact that her husband never told her about where he was going when he left the house:

When he is going to dinner, he doesn't even tell me. There's a man in the house [a neighbour] who will say, 'Madam we're going to dinner, are you not going?' If not I won't even hear it... When he's going somewhere, he doesn't even tell me. When he is going to Accra, he'll wake up at dawn and say 'I'm gone'. No, I don't exist. When he's going to school alone, he won't say, 'I'm going to school.' So when he comes back I just sit there and look at him (int. 7:13).

This respondent explained further that her husband, who was an alcoholic, spoke to her only when he was drunk. On these occasions he would come home to insult her:

He doesn't converse with me ... he won't talk to me. When you go right now, he is holding a book. If you even ask him a question, no, he won't answer you. The only thing he'll do is to go and drink and come and insult you (int. 7:3).

A respondent who described her husband as usually abusive recounted what happened when one day she prepared a meal that he was not happy about:

Yes, for example, yesterday we prepared 'banku' [food prepared with corn dough], so today I tried to make kenkey [also made with corn dough], so that we will eat that as breakfast. After laying the table, he came, opened the plates, and then became angry, and shouted, 'why didn't you make "banku?"' Shouting on me, the whole house was hearing what was being said [she lived in a house with other tenants], so I went into the room and told him that if he is behaving this way, it worries me, especially, if he talks to me like that in front of the children, I feel humiliated. If he has something to tell me, he should tell me in the room, but the way he was talking, asking me if kenkey is also food?... So that is how he behaves (int. 36:5).

She also pointed out that although her husband did not give her enough money for food, he insisted on eating three meals a day and became very angry whenever the meals were not provided:

And sometimes too, I will not have any money, so when I manage to get all of us breakfast, in the afternoon it's only the two younger ones who eat before we cook supper. But he will force, if there's no food on the table in the afternoon, he'll get angry, but he's not giving me money as such (int. 36:5-6).

Other women recounted similar episodes. They said that although some men did not give their wives any money for food, they expected their wives to provide them with food every day:

There are some men who don't care even if their family had eaten or not. But you the woman will try, you'll go to the farm and try to get some food on the table, and he eats it without any guilt (int 6: 4).

Other women described how their husbands ate at the "chop bars" (local restaurants) in town before returning home in the evenings, and did not care whether or not their wives or their children had eaten. One woman told me this story about a friend of hers:

We women suffer a lot. Hmmmm, I have a friend who said her husband had been refusing to eat her food, complaining that there was not enough fish in the soup. It was later on that she got to know that he had been eating in a 'chop bar' (local restaurant). So you see, you'll be losing weight while your husband will be putting on weight because he has been secretly eating good meals in town (int 6: 6).

Another woman recounted an amusing incident in which a man who had secretly been eating delicious meals in "chop bars" was caught one day when he became very sick and threw up and his wife discovered the content of the vomit:

Oh yes! They go, buy food with plenty meat, and when they return home, and you have prepared one of your 'aborbi' [tiny dried fish usually eaten by the poor], then they'll say, as for today, they cannot eat, because they are ill, but if you know the amount of food he had eaten at work before returning?... A man did it to his wife some time ago. His wife was worried about him, not knowing that he had gone to drink too. Before going to eat the food, he became sick. He returned home to tell his wife he had not been feeling well the whole day, he had been feeling sick, so he had not even eaten. It was not long when he started throwing up, they said if you had seen the amount of meat and 'fufu' [usually pounded yam or cassava] that came out? The woman was so shocked, that same day, the woman packed her things and left. She said if she should continue to stay with this man, she will die (int 19: 11).

Thus as the women explained, they worked hard to provide food for the family while some of their partners enjoyed good meals in the local restaurants with the income that should have

been used to help the women to take better care of the whole family. Many women perceived their partners as both irresponsible and cheats, and argued that their husbands' behaviour contributed largely to their multiple responsibilities and work load. These in turn contributed to their ill health.

The Gendered Division of Household Labour

Many women complained that their partners refused to provide for their families. They explained that many of the men either did very little to help, or completely refused to look after the children and the household. One respondent said her husband, a tutor in one of the secondary schools in Kpando, gave her only 20,000 Cedis [approximately CAN \$30] every month to take care of the household. She described how her husband spent the rest of his paycheck on "Akpeteshi" (the local gin) and did not care whether or not the money he gave for the month was sufficient for the household of five:

- r: First I told him that the "chop money" [maintenance money] he is giving me is not sufficient.
- i: Aha
- r: He says there's none to add to it.
- i: I beg ooh, how much does he give you?
- r: 20,000 [Cedis, equivalent to CAN \$30].
- i: 20,000?
- r: 20,000 a month ____ and I told him that it is not enough because out of this I have to buy soap, school money [pocket money for the children when they are going to school], before I buy charcoal and market things.
- i: So if he gives it to you like that, he doesn't give you any again?

- r: [Shaking her head], no, whether it's finished or not finished, he doesn't care.
- i: Then he uses the rest for 'buzz' [gin]?
- r: Aha, when the month dies [end of the month], he wouldn't mind paying the 'Akpeteshi' debt first, sometimes more than 20,000 before giving chop money.
- i: What! Tell me!
- r: Yes, he can owe the 'akpeteshi' [local gin] seller 30-40,000 [CAN \$43-57] a month. (int. 7:5).

To feed the household this woman bought food on credit from her friends in the market.

When the situation became very bad, she relied on a neighbour for food. But while she was doing everything she could to get some food on the table, her husband always returned home drunk:

Hmmm, Sister [addressing me] sometimes even what the children will eat before going to school too is not there. It's sister Georgina [her friend] she will fetch some rice for me to cook for the children, but before he comes back from town, he is as drunk as a bee (int. 7:12).

Another woman pointed out that some husbands deliberately decided to provide less expecting women to supplement the money by working even harder:

Yes, because of the economy men in general, they're not compromising with us, especially if they know you're working, they sometimes leave all the problems, almost all the problems on you the mother. That is why we, some Ghanaian women, we toil like that, because you want to make ends meet (int 43: 5).

Another respondent pointed out that her husband paid only the rent. Buying the food, water, soap and any other items needed in the household was considered to be her responsibility.

She admitted that the expenses she covered were far more than the money provided by her husband to pay the monthly rent.

Another aspect of their husband's attitudes which women complained about was their unwillingness to help, especially with household chores and child care. Women pointed out that they were solely responsible for domestic work despite the fact they contributed to the household income. Their husbands' refusal to help had increased their already heavy work loads. A trader complained that her husband never helped with household chores when he returned from work. Instead he went to town to drink with his friends:

He won't [help] when he comes back, and he doesn't take pen and paper [do his schoolwork], he's gone to town and will come back in the night. He's gone to town, he's gone to drink beer or 'Akpeteshi' [local gin]. He'll go and drink and come back in the night (int. 40:7).

She said that her business sometimes kept her away from home, and although her husband always returned from work before she did from the market, he always insisted that she prepare supper. Although their daughter was of age and could cook, her husband was unwilling to eat the food prepared by their daughter. This woman was thus usually forced to leave the market for home to prepare the evening meal at the time that business was most brisk:

They [men] won't eat their children's food... Yes, some men are like that, even my husband. If his mother is not around, and I don't come back [from the market] to cook, and our child prepares the meal, he won't eat, saying that he didn't marry her. So I have to come back at 4 and prepare the evening meal... and that is when people buy. They have closed from work, and will pass

through the market before going home, so business is usually brisk by then (int 40: 5).

A similar complaint was made by another woman who was very bitter about her husband's refusal to help with the household chores and childcare despite the fact that she was the one who had an office job. She had asked her husband to pay for household help since he was unwilling to help, but he had refused. In the following conversation with me she describes her marital problems:

- r: Married life is hard, if you are not patient.
 i: So what other problems are in married life?
 r: Sometimes too the man will not help with taking care of the child.
 i: Aha
 r: You alone, if you need a maid too, they'll refuse.
 i: Why? Did you ask him to get you a maid?
 r: Yes.
 i: And what did he say?
 r: He says he doesn't have money to be paying a maid.
 i: Aha
 r: And me alone, I have to do all the household chores, go to work, go to fetch water.
 i: Oh, so you fetch your own water too?
 r: Yes
 i: And he himself is not willing to help?
 r: No all he does is to eat, dress up and go to town (int 69: 3).

She said that when she complained about her husband's behaviour, he retorted that if she did not like his behaviour she could go back to her home town. Similar complaints were made by several other women I interviewed. They felt that as they were also working outside the home, it would be appropriate for the men to help with household chores. Thus, although women were aware of the gender division of labour existing in the Ghanaian society, they

had started questioning it, and were accepting the division only grudgingly. Women seem to be realizing much more how heavy their workload is and they are starting to expect more of their husbands. But still they are torn and continue to feel responsible for their household chores.

Infidelity of Partners

The infidelity of their husbands was another major source of worry and concern for women. One young respondent said several women knew their husbands had many concubines in town. This woman described how some of their husband's lovers even taunted the wives by telling them how helpless they were despite the fact that they knew the identities of their husband's lovers:

- r: What I worry about is my husband's behaviour, that is what worries me most.
- i: Aha
- r: He likes women too much.
- i: Does he bother you with them? Does he bring them home?
- r: He doesn't bring them home, but I've been seeing them in town. When I hear about it too I ask him, and he doesn't deny it.
- i: And do these women worry you?
- r: Yes, some of them bother me in town, they insult me.
- i: Can you give an example?
- r: When they see me, they taunt me by saying 'it's paining you anyway' (int. 46:2).

Some of the confrontations between wives and their husband's concubines resulted in street or market fights. I witnessed a few of these fights. One of the women said her husband's

infidelity had resulted in the births of two children, each with a different woman in the town. It worried her that her husband had still not changed his behaviour. He was still "sleeping in town" and returning the next morning. This behaviour worried her so much so that she had been having severe headaches and losing weight. Her husband's infidelity had also led to her frequent use of painkillers:

You see, when it happens that way, I lose weight. I will be working, I'll be counting money like this, I will be eating whatever I feel like eating, but I'll be losing weight. I can take four or five Paracetamol, but I won't feel okay, because my head will be aching. They say diseases are many, AIDS is common, and when you sleep at home, then the man goes to town and comes back home the following day at 5 a.m. (int. 40:9).

The concern that they may contract HIV and other sexually transmitted diseases from their unfaithful husbands was also a major concern to many women.

One woman talked about her friend who had lost a lot of weight as a result of "thinking too much" about her husband's infidelity:

- r: Oh yes, I have a friend who thinks until she has even lost her structure, she has lost so much weight.
 i: What has she been thinking about like that?
 r: Her husband's 'tukara.'
 i: What has her husband been doing?
 r: [said in English] Her husband has been flirting with a flirt [has been sleeping with another woman], and this my friend is not the type, she wants a home, and this man goes from woman to woman, and I mean, she thinks a lot (int. 43:9).

Several women said that the impact of these kinds of worries caused their weight loss. One woman made this connection clearly: "I became like a strand of a broom, I became thin,

because I was always worried" (int. 19:2). As I pointed out in an earlier chapter, losing weight is an important issue; to most Ghanaians, thinness indicates suffering, hunger or malnourishment or even illness.

One woman talked about how she felt betrayed by her husband when he left her for another woman. According to her, she helped her husband to become established financially after which he walked out on her to live with another woman. She said after all the help she gave the man, she had now become the man's "carpet" (meaning she was no longer important to him). She believed that such experiences led to "thinking too much" and could give women hypertension:

Me for instance, like my husband and I, mine is with husband problems. You and your husband are there [living together], and you have not done anything wrong, you have not offended him, and one day, he just stands up and leaves you. He'll always be doing things to offend you, the chop money that is not enough, he won't give you. You see, you'll be thinking, and you'll be saying 'what at all have I done to this man for me to be treated this way?' Sometimes when you ask him, he'll say you've not done anything. And for you to have a happy marriage, it's expected that both of you become united, but if you're not, it's a problem. It hurts, sometimes you'll like to see your husband, or your child will be sick, and you want some money to send the child to the hospital, but you won't see him. This becomes your sole responsibility, you'll be worried, you'll say, 'Oh! Is this me?' (int 12: 6).

Another woman who had not seen her husband for the past seven years made this general comment about how some men betrayed their wives, which in turn gave rise to mental illness in women:

Sometimes, you see, travelling is common now, and you're with your husband, fine, and then he tells you. Stay here ooh, you and the children, I'm travelling,

when the month dies [ends], I'll come back. He'll come, he'll come. And you'll be sitting down waiting for him to come back, and then somebody comes to tell you that he saw your husband with another woman, and he's wedded the other woman [laughing], what will happen? You'll get 'basaa' [messed up, confused or mad] (int. 10:4).

Abandonment, feelings of betrayal and lack of social support from partners were among the sources of women's poor psychosocial health.

Effects of Polygynous Marriages on Women

Polygynous marriages are very common and generally accepted in Ghana. Although some of the women I spoke with claimed they did not have any problems with this marriage arrangement, the majority of the women said that there were problems associated with such relationships. They argued that their relationships with their husbands and co-wives usually involved a lot of stress, tension, jealousy, quarrelling and fighting. Some women believed that such stresses and strains could make women develop high blood pressure, or cause weight loss:

Sometimes stress, yes stress, you know this time, the men say the women are more than the men so they go about chasing other women. You see, that sort of polygamous life, that too, such things worry us ... Yes, in our homes, so sometimes if you're not careful, you'll be thinking aaah [for a long time] until you develop blood pressure or sometimes you'll even lose your form [lose weight]. Yes, that's our problem, as Ghanaian women (int. 43:6).

A 35-year-old woman recounted her experience of sleepless nights and weight loss when her husband took another wife:

At first my husband and I were there for a long time, then he went in for another woman. This worried me a lot. If your husband goes in for another woman, you'll worry, it will disturb you ... Those days when I went to bed, I couldn't sleep... And when I go to my parents, they complain that I'm losing too much weight ... When they see me, they say, 'Sister, why are you losing so much weight?' (int. 47:4).

Other concerns women expressed about polygynous marriages centered on the emotional and financial losses that they usually experienced after their husbands married other women. Although their husband's incomes remained the same, the introduction of more wives reduced the amount of "chop money" (maintenance money) each wife was usually given. In other words, the number of mouths to feed increased as a result of the man marrying more women and having more children and the quality of life for the entire family declined. In many instances, the favourite wife (in most cases this was the new wife) received more financial assistance than the current wife or wives. This was the situation one of my respondents faced. When her husband married another woman their relationship became strained. Her husband became abusive and her family's quality of life worsened:

When I say something, he'll insult me, and tell me stupid things. If he has to give you 1000 Cedis [about CAN \$2], he will divide it into two, and maybe give you less. If you complain, he will beat you (int. 47:4).

She explained how helpless she felt because it was impossible for her to leave her husband since the earnings from her trade in bathroom slippers could not take care of the children:

But because of the children I can't [leave], because this 'charley wortey' [literally, 'Charley let's go,' a name for bathroom slippers] can't pay their school fees. I can't afford to pay their fees (int 47: 4).

The worst situation, according to one woman, developed when both partners were unemployed and the husband insisted on taking another wife. She said in such circumstances women felt helpless because tradition continues to permit men to marry more than one wife even if they cannot afford to take care of them:

Yes, what worries we women is your husband is not doing any work, the woman too is not doing any work, so you're hustling to make ends meet, and upon this, the man goes in for another wife! That is our problem in Ghana _____ he goes for another wife, and this wife will start bringing forth children. So these are worrying, but because of our tradition, um _____ I mean, if you talk no one will listen (int. 43:15).

In addition to the financial problems they associated with polygynous marriages, some women held the opinion that polygynous marriages led to "broken homes" and teenage pregnancies. They explained that women who could not cope with the stresses and strains of polygynous marriages separated from or divorced their husbands to live on their own with their children. They argued that these women usually had insufficient resources to adequately care for their children. For the household to survive, the children were forced to take up trading at a very young age. The result was often that some of these children eventually dropped out of school. While struggling to contribute to the household income, girls were sometimes forced into prostitution or into giving sexual favours for money and food. Sometimes teenage pregnancies resulted.

We see from the women's accounts above that they face a dilemma in their relationships with their partners. They attributed their worries, difficulty in sleeping,

headaches and other health problems to the fears and conflicts that marked their relationships. Yet they feared breaking up with their partners as this also came with its own set of problems. For the women I interviewed, therefore, staying in relationships or breaking up both had negative implications for their health.

MOTHERS-IN-LAW

In Ghana, a newly-married woman sometimes lives with her husband's extended family, which includes her husband's mother, or step-mother or both, and other relatives. Such a living arrangement, some of my respondents pointed out, had some advantages; one woman explained that it was very convenient for childcare. She pointed out that she did not worry about travelling because her mother-in-law was always around to take care of even her youngest child. She also talked about how such arrangements meant that women had help with household chores:

Sometimes my mother-in-law is also around, so she prepares the soup before I return [from the market]. Then the children will come to me in the market for cassava. By 5 o'clock, they put it on fire, so by 6 o'clock, I'm home, then we will pound it and then eat supper... But if I have been at home with only my husband and children, I will do more 'tukara' (int. 40:4).

Another young woman mentioned that since her husband was not yet well established, her mother-in-law took care of her and her co-wife. She said despite the fact that her husband was not treating her well, she was still living with him because of the encouragement, support and good treatment received from her mother-in-law:

- i: And what is the relationship between you and your mother-in-law?
 r: As for her, I won't lie to you, she's just taken me as one of her children.
 i: Aha
 r: Sometimes, I feel like leaving him [her husband] and leaving the child behind, but when I think about the way she treats me, I have not yet had the courage to do it (int. 52:4).

Thus, for some women, extended family living arrangements are beneficial as far as childcare, household chores and emotional support are concerned. It seems to be the case, however, that these same household arrangements are also plagued by tension and misunderstandings which affect women's health in many ways. Tension between daughters and mothers-in-law often resulted in a lot of thinking, anxiety, worrying and headaches for women. A mother-in-law's refusal to help with chores in the house could also result in extra work for an already-overworked wife, and this translated into tiredness and physical pain for women.

Some women complained that their mothers-in-law disliked them and did not hesitate to show it. One respondent explained that her mother-in-law was always rude to her and did not help with the care of her grandson. As a result this respondent's work load was always very heavy and this made her very tired and weak:

- r: My mother-in-law also worries me, she is rude to me.
 i: Like what?
 r: She asks me questions that she has no right to ask me.
 i: How do you answer her?
 r: I don't mind her, I just look at her. When she talks and gets tired, she leaves... I try to tolerate her. Hmm, mothers-in-law can give you hell. When I was living with them at Aziave and had my son, instead of her

- babysitting for us, she never asked. I had to bring the baby to work every day. Then later on, my sister came and started helping.
- i: But that is her grandson?
- r: Yes, and she is not doing anything, she doesn't work, she is always at home. That is why I left that house (int. 69:4).

Asked why she felt her mother-in-law did not like her, the respondent explained that her mother-in-law was not happy about her:

I think she doesn't want her son to marry from a different town, because one day she was telling me that she saw a girl whom she felt would have been a good wife, and here he was following somebody like me (int. 69:4).

Some mothers-in-law, a woman pointed out, felt wealth was usually transferred into another town or ethnic group when their sons married women from different towns or ethnic groups: "They want a woman from their home for their son... they want a woman from their home town to enjoy the man's wealth" (int. 43:10). One young woman explained that her mother-in-law disliked her so much that when the mother-in-law came to visit, she took over the kitchen, prepared the meals and saw to it that the daughter-in-law did not take part in eating those meals. Whenever this woman heard that her mother-in-law was coming to visit she became anxious and depressed.

In Ghana, a marriage is understood to be between families rather than between individuals. When a marriage has been blessed by the extended families of the couples, for instance, a man or a woman who is "misbehaving" can be summoned by family members and reprimanded. Being disliked by one's in-laws, then, is a difficult and serious situation for any

of the couples in Ghana. In some cases conflict with in-laws leads to divorce or separation. It is also known that harmonious relationships with in-laws can save marriages.

LONELINESS AND FEELINGS OF ISOLATION

While several of the women I interviewed were concerned and worried about their relationships with their partners and in-laws, women who lived alone were lonely and felt isolated. They said they were unhappy or depressed because they did not have partners. One single woman described how lonely she always felt because she had nobody to speak with: "I worry about being single. It's important to speak with somebody. So loneliness, I'm always here alone, alone ooh" (int. 3:18).

For some women, the issue was not the need for a male partner specifically. They felt that it was important to live with somebody because they might need assistance. A middle-aged woman who lived alone recounted how ill she had felt one night and how she could not find anyone to talk to until the following day:

Last time too when I was lying down, I heard my heart beating in my head, 'kpla kpla kpla kpla!' When it happened I got scared, I got out of bed and sat down. It is not good for anybody to live alone. By all means, you need to live with somebody, even if the person is not your husband (int 30: 3).

Several of the women I interviewed thus expressed the view that having "nobody to talk to" was quite depressing and increased their feelings of isolation. In the case of the woman

quoted above, one danger of living alone was that it became difficult to obtain immediate comfort or help when one fell seriously ill.

While married women complained about problems associated with being in relationships, many of the single women talked excitedly about the advantages of having a partner. They felt that having a partner would mean they had somebody from whom to seek advice and help in solving their problems. One of the women felt that it would be comforting to always have someone "intimate" to discuss issues with; she thought this might reduce her worrying:

Hmm, you see I live alone. Sometimes you'll be thinking about something, and you would be saying that if I were living with somebody, I would have discussed this with the person and this may be comforting. But if you're alone, you continue to worry. If you don't know how to take care of yourself, it will keep on affecting you, so that's what has been worrying me (int. 30:3).

Another woman who had been married and divorced twice talked about the importance of having a companion. She said that having a companion helped to offset the loneliness that many single women experience:

As a single woman, naturally there is the time when you need or you feel you need a companion, a partner, to share your views with, to share your joys, your sorrows with, it's something natural. Sometimes you'll wish there were somebody with you, so you feel lonely. (int 74: 10).

The need for a partner for comfort, advice and companionship was thus important to many women who lived alone. They believed that having a companion would reduce their feelings of loneliness and depression.

Many women also said that they were sometimes looked down upon by society because they were not married. Unmarried women command less respect than married women, and some of them are even suspected of engaging in prostitution:

Okay, single women, they take it that we are not married, so some people think that because you are there [unattached], any man at all can come to you. You are alone at home so people will think that every day men come to you and sleep with you ... That's what they think (int. 9:3).

This respondent pointed out that this perception was not limited to single women; it applied to married women with absentee husbands too: "Even some women who are married and their husbands are not with them, they think about them like that" (int. 9: 3). Furthermore, women who were single or divorced were often perceived to be unmarriageable because of their supposed insubordination:

Those who, because of problems in the marriage, they have left their husbands, most of the time, they'll say that if the woman's behaviour was good, the man will not have left her. But they don't know what was inside before the woman left (int. 9:3).

These perceptions, as many women pointed out, made them worry and think a lot. They said that not having a husband made them feel incomplete and this affected their sense of self worth. It also contributed to their depression.

The situation of women illustrated an interesting paradox. While on the one hand some of my respondents, especially the single women brooded over their plight and were worried because they were lonely, some of those who were married were contemplating leaving their "unsuccessful" or "bad" marriages. But for many women marriage was a

necessary evil. While it could result in social respect, companionship, comfort and advice in times of crisis, it could also bring challenges and problems which affected women's health. The following quote captures vividly how women perceived the challenges involved in marriage:

This marriage problems ooh, if you don't get married too, it's a problem, when you get married too it becomes a problem. As for marriage, it's like 'hlomade Kotoku, kpakpla ha dor ye, makpla makpla ha dor ye' [marriage is like a sack used to carry food, and as useful as the sack may be, it is very bulky and uncomfortable to carry, so using this sack causes as much discomfort as not using it].

To most women therefore being either single or married was a challenge with which women must contend. Neither option was entirely good; both situations had their benefits and problems, and both situations were sometimes detrimental to women's health.

MOTHERHOOD IS MADDENING

On one of my typical days in the field, a conversation with two of my respondents developed into an entire discourse on motherhood and the difficulties it entailed. One of them told the following story to explain the impact children have on mothers:

Two childless women went to see a medicine man for help to have children. The medicine man asked them if they wanted to become mad. One of them said 'yes', while the other one said 'No.' He treated both of them and sent them back home. Later on, the woman who said she was willing to become mad got pregnant and had a child. The other woman who was unwilling to become mad could still not have children. The childless woman went back to the medicine man and asked why she was not having children. She argued that her friend who was willing to become mad was still not mad and had even had a child.

The medicine man explained: 'Telling children, "Don't do this! Don't do that!" is the madness I was talking about. The reason why you have not been able to have children is because you don't want to become mad' (int. 6:1).

In this account an equation is being made between raising children and women's mental well-being. In a subsequent conversation the respondent who told this story pointed out how maddening she felt the experience of mothering could be:

'Don't do it! Don't do that!' is not easy. We mothers suffer a lot, you know, you don't have to remove your clothes and be walking about naked to be mad. Your children can make your life "bassaa" [messed up or confused]. Even what you experience at home can make you mad (int. 6:1).

While caring for children could thus be satisfying and rewarding for many women it was also a stressful experience, both mentally and physically. But while they perceived motherhood as a sacrificial and stressful job, women nevertheless pointed to the importance of having children. In Ghanaian communities "barrenness" is frowned upon. Among the Ewe of Ghana, barren women are called "konor" (poverty stricken women) and there is a well-known saying in Ewe that goes: "evi nyowu ga" (meaning, a child is better than money). The expressed preference for children over money is indicative of the high premium placed on children. Thus, it is said that a woman could have a great deal of money, but not having children made her less of a woman among her friends, even less of a human.

The deep concern expressed by the women I interviewed about the welfare of their children is a testimony to the importance Ghanaian women attach to children. Most of the

women I interviewed said they were concerned about their children's health, how they were going to be fed, clothed and educated:

- i: What do you worry about of late?
 r: My children's welfare
 i: Aha
 r: Like school has reopened now, where am I going to get money to pay their school fees, their uniforms and all that? It's a big 'tukara' (int. 29:3).

Another woman's worry about her children were similar to the woman quoted above:

Now what I worry about is my children ... like I think about the future, like, how they are going to progress in school, for example, how am I going to finance their education as they go further. I think about how I'm going to fight to see to it that they get educated. So I worry about this a lot. And the day that you wake up, you don't have anything, I worry too. You'll be saying, 'Ah! Today, I don't have anything, no food to give my children,' and all that. They worry me a lot (int. 13:3-4).

For the women I interviewed, children were their "social security" and their "pension schemes" for old age. They believed that if their children turned out well in life, they would be able to take care of their parents when their parents became old. Most women admitted that giving birth and taking care of their children until they grew up were difficult tasks. They said that as women, they were primarily responsible for childcare. They were also held responsible for whatever their children did and were held accountable for any bad behaviour that their children exhibited:

Being born a woman is not easy at all, no, it's not good ... You see, when you give birth, you have to nurse this baby until the child grows up. If the children are misbehaving too, it is your fault, it's your problem. If the children go to town and bring back trouble, it's you the woman that they will bring that trouble

first, before it goes to the man ... Then the man is also going to tell you that it is you, the woman who is not training the children well ... but you are doing your best (int. 36:4).

A woman complained that her new husband blamed her whenever her children from a previous marriage got into trouble. She said this situation always made her feel uneasy:

Their ears are strong/tough [they are stubborn]. Their behaviour has made me become very uneasy. I don't feel free, because the man too [their stepfather] doesn't like their behaviour, and he puts all the blame on me, so I don't feel free at all at home (int. 36:5).

The woman continued to explain that her children were reluctant to help her with the household chores and farm work, which made her work load even heavier:

The children don't listen to me...For example when they wake up in the morning I have to talk for a long time before they'll do the sweeping. When it's Saturday and we are supposed to go to the farm, they won't go, they'll refuse. Then me alone, if we are supposed to go for food, me alone, I have to go for the food alone, they won't help me (int. 36:5).

She expressed a sense of frustration and helplessness at her children's behaviour and said her children made her feel sorry for herself.

For another woman, the behaviour of her teenage sons was a source of constant worry.

The boys always skipped school to go hunting for bush rodents. The woman explained that she learnt of her sons' misadventures only when their teacher summoned her to their school:

r: A few minutes later, he [one of her sons] returned to tell me that teacher says they should come and bring me immediately. I asked, 'why?' They said that their attendance was poor, especially one of them, showing that he was not going to school at all. I heard later that while I was on the farm, they ate, they won't even wash the bowls. And

then carrying a cutlass they follow other people into the bush to hunt for rats... And they don't bring any meat home too.

i: Hum

r: If you go there and excuse me to say, a snake goes to bite you! What will I do? They make me worry. I think about it all the time (int 50: 6-7).

This woman said she also worried about her children's stealing habits:

r: Listen to this. Last time I travelled. By the time I came back, the woman over there [pointing to her neighbour] and her husband said they caught one of my children in their room. They said their money was getting lost ... And he [her neighbour's husband] beat my child very well, his teeth even got broken.

i: Oh!

r: I was told the whole story when I came back. It was my husband's son who was caught, but they said my son and my husband's son were in it together. They said they had stolen about 25,000 [about CAN \$50].

i: Hum.

r: But before I left I had worked to pay the children's school fees so that they will not be loitering around while I was gone. But have you seen what these children did to me? And I left them enough food too. It's because of them that I don't sell the foodstuffs from my farm. I said I will pay the money [the money supposed to have been stolen by the boys]. Last time I gave him [the neighbour] 10,000 [about CAN \$14], but he refused to collect the money, arguing that he will not take the money in instalments because it wasn't as if I was paying him for things bought from him.

i: Hum.

r: I begged and begged, but he refused. And since then he has been insulting me, insulting me all the time. Last time I was going to the farm, my husband was not in, we were just about to leave when this man asked the police to arrest my son.... We had to go and look for money. We got 15,000 [approximately CAN \$21] and paid it. They told us to come and pay the rest within a specific time, otherwise, they'll come and arrest me. So two days ago, I went to pay the rest of the money. (int. 50:5-6).

She said these were the reasons she was always worried. Her worry also contributed to her sleeplessness and weight loss.

A widow I interviewed experienced difficulty sleeping which she attributed to a string of interrelated problems. She said that the most disturbing of her problems was the irresponsible behaviour of her unmarried teenage daughter who had given birth to a second child. Each birth required a Caesarean operation and the widow had yet to settle her daughter's hospital bills because the widow had been unemployed for several months. She herself was still recovering from an illness which had kept her in bed for nine months:

You see my daughter like that! You see her right now 'kporoe kporoe' [describing her short and stocky daughter as a 'dot'], you see, she is not with any man [not married], a man just made her pregnant and abandoned her ooh. The last child she had, they had to make 'edor' [Caesarean] for her again. No father for the child! And she still owes the hospital. We don't know who is going to pay. And her father too has died (int. 2:8).

She explained that all of these problems were the result of her children not listening to her advice:

Now if you talk to them, they don't listen to my voice [advice]. They don't listen to my voice, I don't know what I have done to them (int. 2:9).

She said there were times when she could not sleep for days. For her, a tranquil mental state of being was a prerequisite for a "good sleep," but one whose "brains are always busy" because of their children is bound to experience sleepless nights.

Another woman mentioned that she was afraid her daughter might be associating with "bad" groups. She said she suspected her daughter had a lover but could not confirm this

because her daughter was quite discrete about her activities. "I'm afraid she will go and do something bad," said the mother. She also mentioned that her daughter's behaviour had been a source of tension between her husband and her:

I'm concerned about her behaviour. Most of the time I quarrel with my husband over that. He blames me for not counselling her and that is why she goes to town so frequently (int. 44:3).

One observes from this quote that apart from having to deal with their children's behaviour women were often held accountable for them. Blaming women for the behaviour of their children created additional stress for them.

It would seem safe to conclude that children who were difficult to control contributed to women's worry and this affected their mental well-being. Several women I interviewed believed that problem children could be a source of mental illness for women:

And some children too, they will worry you day and night, you'll be thinking. You'll be thinking about the behaviour of the child You hold the child this way, but no success, you turn it this way, but no success. You can think about it and go mad (int. 29:8).

For most women being a mother was no easy task. It could be emotionally and mentally challenging.

SUMMARY AND CONCLUSION

This chapter has continued my discussion of the connections between the day-to-day lives of women and their health. Here, I have focussed on the stresses and strains women

experienced in their relationships and highlighted women's beliefs about how their relationships affected their health. Specifically, the women said that their partners' attitudes and behaviours contributed to their poor mental health status. Some of them said their partners were physically and verbally abusive. Others complained that their partners rarely communicated with them. Several women said that their husbands refused to help with household chores and childcare despite the fact that the women contributed financially to the maintenance of the household. All of these sources of tension were said to contribute to women's poor health status.

One important feature of women's lives which emerged during the analysis was the insecurity and helplessness women experienced in their relationships with their partners. They were constantly afraid of being betrayed or abandoned by their husbands, and this added to their feelings of stress and worthlessness. A number of the women expressed the view that the supposed benefits of marriage or a relationship - joy, happiness, emotional and financial support - were illusions. For many of them, being in a relationship increased their urge to be self preserving and alert for any eventuality as their husbands might abandon them, divorce them, leave them for other women or become abusive at any time. In some instances, mothers-in-law added more stresses and strains to the already stressful marriage relationships, thus increasing the insecurity that women experienced. Their children did not do much to ease the tension either. Apart from struggling very hard to care for their children, women had to deal with their irresponsible behaviours of children, especially that of their

teenagers. Problems created by their children were exceptionally hard on women since they were held responsible for whatever bad behaviour their children exhibited.

Women reported constant headaches, depression, weight loss, difficulties sleeping, feelings of isolation (even when they lived in the same household as their partners), and feelings of worthlessness and powerlessness as a result of being in poor relationships or not being in a relationship at all. Women's relationships with others, and their feelings of powerlessness or lack of control over their lives, all contributed to the worry and poor mental health they reported.

As the analysis in this and the previous chapter have shown, the causes of women's ailments are complex when seen through women's eyes. Many factors in the social and material circumstances of women's lives come together to determine their health status. We see women establishing a relationship between their psychosocial and physical health, and the demanding realities of their day-to-day lives. Their responsibilities with respect to social reproduction and production as well as the social support they received within their family reflect gender roles in Ghanaian society. But the women were not resigned to their fate in the face of problems. In the next chapter we will see how women in Kpando are trying to cope with the stresses and strains in their lives. We will also learn how women are solving or managing their health problems. The chapter will further discuss women's suggestions about improving their lives and consequently, their health.

CHAPTER 8: COPING MECHANISMS AND SUGGESTIONS FOR CHANGE

In the previous two chapters I examined women's perceptions of their health and the linkages the women made between their health problems and the context in which they lived their lives. The themes highlighted in these chapters point to the need to understand women's health in terms of women's multiple roles. The data also show that the nature of women's responsibilities at the economic and familial levels have a profound impact on the extent to which their health is affected, and on the resources available to them to maintain their health. Their relationships with their partners, other relatives and children were also identified as sources of stress and strain for women.

In this chapter I look at the ways in which women tried to cope with their health problems. Women depended on medication, either modern or traditional, depending on the nature of the illness and what they believed caused it. Alcohol and religion were also means by which women tried to relieve and resolve some of the stresses in their lives. Women engaged in multiple work activities as a way of diverting their attention away from their problems and these activities helped to offset some of the economic constraints in women's lives. Neighbours and relatives also served as sources of relief in various ways for some

women. However, a few of the women reported feeling so helpless that they did practically nothing about their health problems.

This chapter also looks at the suggestions women made about how their health and their lives could be improved. Their solutions were mainly social in nature. While a few of the women pointed to the need for free medical care and free or affordable medication, most of the suggestions emphasized the need for education and jobs for women. The women also felt there was a need for income-generating activities and that they should have better access to credit and other resources to enable them to trade.

The chapter commences with an analysis of the resources women said they used to cope with the immediate problems they faced in their day-to-day lives and with their health problems. This is followed by a discussion of their more general suggestions for change in relation to Ghanaian women's lives and health.

METHODS OF COPING

Medication

In order to discuss in a meaningful way women's methods of coping, especially, their reliance on medications and their patterns of medication use, it is important to reiterate how unending Ghanaian women's activities are and how indispensable they perceive their roles to be; they had to continue to work. One major theme that emerged in the interviews was the importance women attached to the roles they play in their homes and in the lives of their

families. Many of the women argued that they were solely responsible for the upkeep of their households. To be able to support their families they often had to engage in more than one work activity at the same time. Even those women who did office work had to combine this activity with farming and some form of trade so that they would have enough money to care for their families. In addition to working to earn some income, women had to see to the household chores. They were primarily responsible for the collection of fuel and water, and for cleaning the house. They also had to take care of the children and cook the meals. In describing their responsibilities, women stressed how indispensable the tasks they performed were. They saw their household chores as not only essential but also compulsory, because as many of them explained, failure or refusal to do them could endanger their families. For instance, if they did not clean their houses or wash the family's clothes regularly, their children could be exposed to infections. If they did not look for food and prepare meals their children and husbands would go hungry. The indispensable nature of women's roles was captured well by one of my respondents when she described herself as the fuel in the truck. She feared what would happen to her family if she could no longer function: "Because right now, it looks like I'm the petrol in the truck, and if the petrol gets finished, where are they going to get some?" (int. 50:5).

Women also said they found it difficult to stop working even when they fell ill. A woman who said she had suffered from hypertension for several months explained how difficult it was for her to rest. She explained that she was the sole breadwinner for her

household. As the whole family depended on her for their livelihood, it was impossible for her to rest even when she was seriously ill:

You see right now, they say I should be resting, but you see, the whole day I have not rested. Because I cannot go anywhere these days [because of her illness], I have been sitting here tying iced water [in small plastic bags] so that when the children come back, they can go and sell it, then we can get money to buy food ... I can't rest, because we have to survive. The economic condition won't make me rest. I have to work all the time, even if I'm not feeling fine (int. 66:7-8).

Another woman explained that as a single parent who did not receive any financial help from her former husbands she was sometimes forced to undertake work, which had she a husband, she felt she would not have to do. She said she had to arrive at work by 2 a.m. even when she was ill because her job would be left undone:

- r: Okay, because I don't have anybody to help me, every day the work that I'm not supposed to do too, I am forced to do it.
- i: Like what?
- r: Like ...look, I will have to wake up at 2 [a.m.] and go to B.H. [Bishop Herman secondary school where she works], do you think if I had somebody to help me, I will be forced to wake up at that hour? ... sometimes even if my body is aching too, I have to wake up at dawn and go, because if I don't go my work will be left undone. Nobody will do it, so I have to force myself and go (int. 34:4).

From my own observation, women's perceptions of their need to work all the time were also influenced by traditional Ghanaian thinking and expectations that the typical woman must never complain, be lazy or show any sign of tiredness. She must be seen to be busy and active all the time. The women felt under constant pressure to meet these expectations. The combination of having to work all the time to support their families and

having to be constantly active to satisfy definitions of women's roles meant that they often became ill or experienced bodily pains but were unwilling or unable to take time off, even to recover from an illness. To cope with their health problems and to continue functioning, women depended on different types of both western and traditional medicines.

Reliance on Western Medicine

Western medicine was introduced into Ghana by the missionaries and the colonial administration (Twumasi, 1981). In the beginning many Ghanaians were reluctant to adopt western medicine and were critical of its effects (Twumasi, 1981:147). Soon, however, people began to believe in its curative power; some were especially drawn by the speed with which it appeared to cure illnesses and diseases. Increasing faith in western medicine led to the use of hospitals, clinics and dispensaries by Ghanaians. Hospitals and health care centres were, however, unequally distributed across the country (Fosu, 1995:1031; Kojo, 1989). Because they were originally intended to cater to the health needs of colonial administrators and their workers, most hospitals and clinics were established in the cities and other urban centres, the seats of governmental administration (Fosu, 1995:1031). For many rural dwellers in Ghana, therefore, the present lack of hospital amenities is a problem. The hospital situation in Kpando is a case in point. With only one main hospital serving the whole town people have to walk or travel several miles and for many hours to see a doctor when they are ill. In the hospital itself, because of the small number of doctors, patients normally stand in

line for long periods of time for their turn to see the doctor. In addition, the unwelcoming manner of overworked and low paid hospital officials such as nurses, often discourages people from visiting the hospital.

Pharmacy shops in Kpando complement the function of the main dispensary at the hospital in providing people with drugs. In these shops Kpando businesspeople sell medication to people who provide prescriptions from the hospital. In recent times pharmacy shops in Kpando have begun to feature much more prominently than ever before in providing health care. Due to the problems associated with going to the hospital and clinics, pharmacy shops are being used by some people as substitutes for hospitals. Individuals report their symptoms to the pharmacists or store owners who diagnose their ailments and administer treatment for a charge. Other people diagnose their own symptoms, decide what medications they need and in what combinations, and go to the local pharmacist without a prescription from a doctor. It seems that because of the growing functions and importance of pharmacy shops, these shops are becoming very profitable businesses in Kpando. The town is witnessing a rapid proliferation of pharmacy shops which are replacing the functions of the hospital and doctors.

In my conversations with women in Kpando concerning their use of western medicine, the growing importance of pharmacy shops in administering to health needs was highlighted. The women explained why they preferred these shops to the hospital. Most women treated themselves when they were ill and rarely visited the health care centres. As

can be seen from the comments of the woman quoted below who suffered from knee pains, monetary considerations are important in determining whether or not women go to the hospital for treatment. Hospital fees are a major deterrent to women seeking medical care:

I don't go to the hospital, I only massage with some Chinese Robb because I don't have money. If I should go they'll collect 5,000 Cedis [CAN \$7] from me. The X-ray too, it's expensive. Even if it doesn't get better too I go on with my life, sometime I forget about it (int. 11:4).

Lack of time was another important reason for not visiting the hospital or the health care centre. As their daily activities leave them with no spare time the women felt they could not afford to spend long hours in hospital waiting lines to see a doctor. As this woman explained, it is faster and far more convenient to make a quick visit to the local pharmacy for medication, come back and continue with one's activities:

Because that one [the local pharmacy] is faster, you go to the hospital and queue for several hours, and it will take a long time before the nurse will call you to see the doctor. You can wait for more than five hours before you see the doctor, sometimes if you go in the morning, you'll return in the afternoon (int.6:9).

For these women, who have no money and have to engage in multiple activities at the same time in order to put food on the table for their families, securing health care from the clinics or hospital was often prohibitively costly in terms of both money and time.

One woman confided that she and her husband were suffering from a venereal disease. They had tried to cure themselves by buying some medication from the pharmacy but the cure was not effective. When asked why they did not go to the health centre or

hospital for proper diagnoses and treatment, she explained that she would not feel comfortable talking about her symptoms especially when people with venereal diseases are held in so much contempt. She preferred to buy medication from the local pharmacy shop to treat herself and her husband. It is clear from her explanation that some women feel more comfortable explaining their symptoms to the pharmacists with whom they are more familiar than the health professionals.

Women's accounts of the ways in which they used the pharmacy shops and their descriptions of the medications they bought revealed a number of different and rather interesting themes and patterns. A typical respondent described how she went to the pharmacist for injections and a combination of pills because of her waist and knee pains:

I go there for injections like penicillin. They give me folic acid, and B'Co [vitamin B complex] too and... then I get better (int 69: 8).

Another woman described with excitement how she reported her symptoms to the pharmacists and how they administered her medication. She sounded happy with their diagnoses and medication because she said they always made her feel better:

When I go to the drugstore and tell them, 'today when I went to work, my whole body didn't feel good' ... then they will combine some tablets for me. There is one that we call 'abrewa bebor ball' [Indocid], and another, B'Co [vitamin B complex], and also Paracetamol and blood medicine, all mixed up.... When I take them, then I sleep well, and by the following day, I feel better (int. 34:8).

Women also described how they or the local pharmacists mixed different kinds of medication in treating their ailments: "I combine it [Paracetamol], with B'Co [vitamin B complex] and "Abrewa bebor ball. [Indocid]" (int. 62:7).

One respondent explained that in deciding on the medication she needed to cure her ailments by herself, she was guided by the prescriptions her doctor gave her when she had visited the hospital with similar symptoms:

With slight signs of illness, I buy drugs myself [laughing] ... which you talk about as drug abuse... I buy painkillers. Sometimes it's necessary to get some antibiotics of your own [laughing] because you know, the prescriptions the doctor gives at times when you have such symptoms, you go and try your hand at curing yourself (int. 18:14).

One woman admitted that she depended heavily on Valium from the local pharmacy to help her sleep:

When I go to bed, I can't sleep. I'll go and report and they'll give me Valium, ten milligrams. I'll come and take three tablets, but still I can't sleep ... Yes, I can even take four tablets (int. 66:7).

Another woman believed that she had taken so many sleeping pills in addition to other combinations of drugs that the sleeping pills were no longer effective:

- i: What kinds of medication do you take when you are not feeling well?
- r: Paracetamol, Alagbin, so that when I am feeling cold, I will feel better. And when I'm not sleeping too, I take Valium, and they told me that I was taking too many Valium ... Now it's no longer effective, now I can take 20 milligrams and still can't sleep (int. 66:10).

From these accounts it is clear that in many instances the women practiced self-medication. Some even relied on prescriptions from friends, or decided on the prescriptions by themselves. For others, one visit to the hospital and a prescription from a doctor was enough to give them an idea as to what medicine they should buy the next time they experienced a similar illness. From their accounts, particularly those focused on how they combined their medications, one sees women showing a lot of creativity and ingenuity.

The Importance of Pain Killers to Women: "abrewa bebor ball"

As women felt it was necessary for them to remain healthy and keep going in order to support their families, they relied very heavily on painkillers. One of the most common medications women cited as very effective in relieving their bodily pains was the pill called Indocid¹ which they nicknamed "abrewa bebor ball," literally meaning, "the old woman can play soccer." The same pill is also known by such nicknames as "strong old lady" and "quick action."

It is a common practice in Ghana for people to give local names or nicknames to modern and traditional medicines. In most cases the names given reflect the way people feel about the medicine's effectiveness in curing an illness. The nickname "abrewa bebor ball" therefore indicates just how effective women think Indocid is in providing a remedy for their pain. It is seen as capable of restoring strength, even to an old lady; it might even enable her to play soccer. But the significance of this name goes beyond the effectiveness of the drug.

That a drug has been named "abrewa bebor ball" is a commentary on the lives of women. It reflects women's belief that in spite of the difficulties they face daily and in spite of their ill health (which often makes them as weak as old women) it is necessary that they remain healthy and strong so that they can keep on supporting their families. The name symbolically reflects the way women perceived the drug Indocid and other forms of medication such as Paracetamol as "allies" and sources of strength in their day to day lives.

A woman who explained that her work involved walking long distances said she relied on medication from the pharmacy shop to enable her to get ready for the following day's work:

- r: Because I have walked for so long, I will be very tired, so when I return, I'll go and buy some pills.
- i: Like what?
- r: You see as for this place, "abrewa bebor ball" is the commonest, they are calling it Indocid.
- i: Aha
- r: Yes, and Buphim.
- i: Aha, what else?
- r: Sometimes they will mix them up with B complex, cod liver oil. Then I buy Novalgine, too, then I take all these. I sleep, the following day, I wake up and continue my work.
- i: No rest?
- r: No, if you are not on a monthly salary, then you have no choice. You have to work hard, there is no pension (int. 40:13).

This respondent had to depend on a combination of medications to ensure that she could work. For her there was no time for rest if her family were to survive.

The general belief in the efficacy of Indocid was affirmed by a woman who explained that even the weakest person who took the medication could become strong enough to play a strenuous game:

- i: Do you take "abrewa bebor ball?"
 r: (pointing to some on her table). That's the name we gave it, it's called Indocid, because it gives you strength. Even the weak can become strong and play soccer (int. 66:10).

Another respondent pointed out that the medicine always rejuvenated women for the following day's work:

Yes! When you work the whole day on the farm, you come back, you take it and sleep. By the following day, you're ready for work ... As for that tablet, it's excellent! (int. 62:7).

She continued to explain how effective this drug was by saying that it was used by many of her friends who walked long distances to trade in neighbouring villages and towns. On their way back to their village they passed by the local pharmacy shop to buy some of these pills:

We go to buy them. When we carry the load to the market like that, after selling it, you pass through the drugstore and buy some before you go home ... Like me, if I sleep and wake up, even if it's 12 midnight, I won't sleep again until the day breaks. But with this "abrewa" [Indocid] tablet, when I sleep, I don't wake up till the following day (int. 62:7).

Many women admitted, however, that Indocid was being abused by some women they knew.

A woman explained that the way some of her friends used the medication amounted to its abuse because they took too many when they wanted immediate relief:

Like this "abrewa bebor ball" [Indocid], some women take them in excess. If they say they should take two, they'll go and take three, four or sometimes six, because they want immediate relief (int. 71:8).

Another medication used in a way similar to Indocid is Paracetamol. One respondent explained that many women constantly carried, pain relievers such as Paracetamol along with them and frequently swallowed the drug to relieve their persistent headaches:

They carry Paracetamol tablets on the edge of their cloth like roasted corn². The least thing, they take some out and chew ... So when they pour some of the Paracetamol into their mouth like that and chew it, they feel better ... Wherever they are, they have it, they tie it at the edge of their cloth, farm, everywhere. They have it, because they experience a lot of headaches (int.71:8).

Another woman said she depended on pain relievers and Labrum to help her through her persistent thinking and headaches:

- r: It [headache] comes every time because you're thinking all the time, you can't stop thinking, so every time.
 i: Okay, so what kind of medicine do you take?
 r: Mmm ___ like Labrum, and Paracetamol and things like that (int. 50:8).

As many women pointed out, life must go on. They said they could not afford to slow down because if they did, their children would go hungry, they would not be able to pay their children's school fees or provide for their other needs. Thus, despite the fact that they were not feeling well, they had to keep on moving. They suppressed headaches and bodily pains with painkillers to enable themselves to continue to play their roles as wives, mothers, caretakers, office workers and heads of households.

Traditional Medicine

In spite of the growing popularity of western medicine many people in Ghana have not abandoned traditional medicine (Twumasi, 1975). Traditional medicines are usually prepared with herbs, roots and the barks of trees. While western medicine is noted for its ability to provide quick relief from illnesses and pain, traditional medicines are believed to operate more slowly and to cleanse the body of impure substances. Traditional medicines are believed to be more thorough and to have a more prolonged curative effect on the body than western medicines. They are also noted for their ability to cure illnesses believed to have been caused by supernatural agencies (Opoku, 1978:149; Twumasi, 1975). Even though traditional priests and priestesses and other ritual specialists generally prepare traditional medicines (Opoku, K. A. 1978:148-151; Twumasi, 1975) the main dispensers of traditional medicines are the medicine peddlers (Fosu, 1995:1031). These men and women move from place to place singing songs in praise of their medicines and selling them in markets, in passenger trucks, at lorry parks³, and from house to house or stall to stall in the marketplace. Medicine peddlers not only sell medicines but also teach people how to prepare medicines from local herbs and roots. In more recent times some medicine peddlers have begun to sell forms of modern medication in addition to traditional medicines.

Many of the women used various forms of traditional medicine which they bought from the peddlers or which they prepared themselves to relieve their illnesses. A respondent who said she experienced general weakness in her body described how traditional medicine

was effective in curing her. She was convinced that traditional medicine was sometimes more effective than western medicine:

I fell ill again, my head! My arm! [she couldn't lift her arms]. The doctors made blood test, urine test, but they could not determine the cause ... So I started visiting traditional healers ... Even right now even if somebody should have stroke, the traditional healers are better at curing stroke than hospital people ... So I started using these herbs, and I observed that I was becoming better (int. 17:8).

Describing a similar situation a woman who said she suffered from hypertension explained her reasons for preferring traditional medicine to western medicine:

I take the medicines that they gave me in the hospital, but I'm also drinking some boiled herbs. When the illness [hypertension] started my urine was very small, like a tablespoon, and the colour will be very brown to red. Sometimes for a whole day I won't urinate, but from the time I started drinking the herbs I have been urinating a lot ... So the herbs are very good for me. Even because of that I have refused to go back to the hospital for admissions. If I go I won't get the chance to drink the herbs (int. 66:8).

In many Ghanaian societies people use both traditional and western forms of medicine. They see the two forms of medicine to be complementary, or one supplementary to the other and find it useful to use them both, often in combination. Many of the women in this study explained that they blended western methods of medication with traditional ones depending on what they believed to be the cause of their illness. This woman used a combination of modern and traditional medicines for her stomachache:

I go to tell them [pharmacists] that I want some medicine for stomachache. They combine some for me, but I boil some herbs too (int. 13:5).

Another woman said she used modern medicine to help her to sleep well and depended mainly on traditional medicine for her illnesses:

The traditional medicine was more helpful. The 'white man's medicine' [modern medicine] only makes me sleep. When I wake up the illness is still there (int. 2:30).

Traditional medication was not always seen by my respondents to be effective or without problems. People were sometimes suspicious of its side effects. One woman recounted how she had severe diarrhoea after taking a medication she bought from a traditional medicine vendor:

- r: Last time I was returning from Accra, and one of these medicine vendors brought some tablets into the bus to sell. He said it was good for waist pains, so I bought some.
- i: What is it called?
- r: I've forgotten, I don't know.
- i: Have you taken them?
- r: I have swallowed two. I'm supposed to eat before I take the tablets. When I took it, it worried me a lot, I went to toilet several times. I learnt it cures fever too, it cures waist pains too, if your knee is also paining you, it'll stop. So when I heard that, I also bought some. He said I should take the tablets again on the third day, but I didn't because of the way I felt when I took it for the first time, I became afraid [laughing] (int. 13:5-6).

Medication, both western and traditional, was a significant means by which women coped with their day-to-day health problems. They self-medicated, relying on pharmacy shops and medicine peddlers for their supply of medication. To enable them to continue to go about their daily activities, they depended heavily on painkillers and sleeping pills. For some women, however, the use of medication was not enough. The complexity of their

problems and life challenges called for other ways of coping. Religion was mentioned as one other coping mechanism.

RELIANCE ON RELIGION

Many women said their belief in God had been an important source of help for them in times of hardship. Some of them were heavily involved in church activities. A single mother pointed out that apart from church attendance itself being a source of joy to her, church activities minimized her loneliness:

All my joy and everything is in the church... so I engage in a lot of church activities. I'm also in the Healing Group, so sometimes they'll give you the responsibility to pray and fast for somebody. If you stay in the chapel and you engage yourself in these things, you won't worry about any of those things [having a partner] again, you won't need to talk to anybody (int. 66:3).

Another woman explained that she was very much involved in church activities and had a very important position in the management of the church's affairs. These activities, she said kept her very busy and active:

I do participate a lot in church activities, and by the status I have in the church, I have a lot of meetings to attend. Maybe I should say I'm a member of the council, ruling council of the church which we call 'Synod Committee,' that is the highest body of the governing body of the church, I'm a member of that, and because of this, there are a lot of meetings which we attend once in a while and supervision of local churches' activities. So these are things that take me out (int. 18:4).

Many women explained that their activities in church associations gave them a sense of self-worth. Members of these associations engaged in a number of interesting activities. During my stay in the field the members of one of the associations went on a field trip which sparked off many controversies in the community, especially among the partners of these women. Their partners, I was told, were not pleased with the idea that the women were leaving home for the whole weekend and, worst of all were going to spend the night in a hotel ⁴.

As a result of being members of a church, women were able to get counselling from other church members or from the priests and pastors of the churches. A trader who had gone bankrupt when she had to finance her father and mother-in-law's funerals explained how her pastor had been of great help to her in her predicament. He had given her spiritual guidance and was trying to get her some money to enable her to recommence trading. The combination of attention from her pastor and her own religious practices had lessened her worrying:

Pastor says I should come back at the end of the month, and I believe that he will be able to get me something. If I get that money, I will be able to do some trading. He has also asked me to come so that we do some fasting so that I will tell God my problems, and I believe that, that will go a long way to help, because any time I do that I see an improvement in my life. I no longer worry the way I used to. I feel like I have gone to bring back something great from church (int. 39:6).

Many women expressed the view that they always received consolation from God and believed that God would continue to protect them. They expressed their beliefs in a number of similar phrases: "Putting everything into God's hands," "Trusting God," "God will

help," "God will protect us," and "It's because of God." A woman whose husband had been unemployed for some years and who complained about having too many responsibilities explained that she was able to cope with the demands on her because she was Christian: "It got to a time that I was getting fed up. So it's the Christianity that is giving me the courage" (int.5:7). She explained that her Christian faith had given her the strength she needed to be able to tolerate all the problems she was experiencing and this saved her marriage:

Were I not a Christian, I'm sure the relationship between me and my husband would have been spoiled. But the scripture says that we should not divorce our husbands, so I can't divorce him too. Secondly, broken home, it will spoil things for the children, it will spoil things about me too (int. 5:12).

She explained further that her faith had provided financially for her family. She described how she sometimes left work, went home and realized that she had nothing to cook for her family to eat. This made her worry a lot but she always consoled herself by praying to God: "I pray, and God helps me. I get something by all means ____ I get something for them. Being a Christian is good ooh" (int. 5:12). Christianity has thus been a valuable source of comfort for many women.

A single mother I interviewed said her former partner had refused to help care for their daughter. She was not ready to report him to the officials of the Social Welfare Services Department, however, because it was against her religious faith to do so. She believed that God would vindicate her in the long run by punishing him:

Her father [the woman's former husband] left this town when she [their daughter] was nine months old. She was in Class 1 when he visited. Since then, she has not seen him again, and she is now in J.S.S. 1 [junior high school]. Her father has not asked of her, he has never seen her, so even if she sees him on the street she will pass by him, he will not make her out, he won't know that, that is his daughter ... But God is going to pay him back. The rules in our church do not permit us to sue anybody, so if I should take him to Social Welfare, it means I'm suing him and going against the rules (int. 13:9).

Another young woman who found herself in what she described as a loveless relationship explained that when she became depressed she consoled herself by the fact that her belief and trust in God would help her:

But sometimes when I think like that for a long time, I just put my trust in God and say, 'Maybe God will help me and I'll get a place of my own' (int. 52:2).

The paradox of these women's situations is that while religion would seem to be having a cushioning effect on them, it did little to change the conditions of their lives. Religion diverts women's attention from their problems, yet they continue to live in very stressful situations and are sometimes unable to insist on their rights as a result of their faith in religion and their religious beliefs.

RELIANCE ON ALCOHOL

The use of alcohol by women as a means of coping with their day-to-day lives was another issue that emerged in the interviews. Some of the women admitted to having a few

drinks once in a while but most were willing to talk only about the drinking habits of other women ⁵. Many admitted that alcohol consumption was a problem among women:

- i: And is drinking common among women?
 r: Yes, it's common.
 i: Do you know anybody who drinks?
 r: Yes, everybody drinks.
 i: Not the type that once in a while you take a bottle of beer or something like that, but people who cannot exist without taking some drink.
 r: Oh! There are many people who feel for drink 'akpeteshi' [local gin], every day they'll drink. Sometimes by the end of the day, they might have drunk a bottle (int. 66:12).

Another woman exclaimed: "A woman can drink a glass full of 'akpeteshi' [local gin] just like that! Neat!" (int. 18:24). She stressed the fact that some women consume more alcohol than men:

As for that [consumption of alcohol], women surpass men, especially at funerals, that is when you'll see drunken women. Drunken women, ei! In fact they drink very heavily (int. 18:24).

Some of my respondents also pointed out that funeral services and "borborbor" (traditional drumming and dancing) offered women legitimate excuses to drink to excess:

- r: Yes, they don't play with their drink at all.
 i: Do you know any woman who is an alcoholic?
 r: Yes, she is always drunk, she is in Tsakpe. [her friend added: Especially at funerals, they get drunk and fool around]. Even last time, I was returning from church in the evening, there was a wake-keeping in town, I saw a woman who was so drunk to the extent that they carried her to a woman's place. They poured water on her and left her there to sleep it off.
 i: Is it increasing or it's been like that since time immemorial?

r: It's increasing, because that is the work of these young ladies. They are all drinking (int. 70: 10).

A trader who had to travel for long distances explained that sometimes she had very little time to eat a meal and was thus forced to go without food for long periods of time. This often led to a loss in her appetite for food. She explained that in such instances, she had to take an alcoholic drink to regain her appetite for food:

So sometimes when I get to somewhere and I want to eat, I have to drink some 'akpeteshi' [local gin] first, because if I go hungry like that for a long time and I eat, my stomach hurts. So I have to drink some 'akpeteshi' [local gin] and aperitif, I will buy some few tots and drink it before I eat (int. 40:12).

Another woman explained that she used alcohol as part of her medication:

If I'm sick like that, I grind some herbs and do enema, and then I buy 'akpeteshi' [local gin], 100 Cedis [about 14 Cents]. I drink the 'akpeteshi' and then eat and sleep. By the following day, I'm okay (int. 11:5).

A woman with an absentee husband said she felt betrayed by her husband when he left her for another woman after she had helped him to become established. She explained that on the days she pondered her misfortunes, she drank alcohol, ate and literally slept her problems away:

r: When it happens that way, when I'm thinking too much, what I usually do is that, when I finish cooking, I'll go and drink 'akpeteshi' [local gin], then I eat a lot, and then quietly I go to sleep, then at least that day is gone.
 i: How much of the gin do you drink?
 r: About 200 Cedis [about 30 cents for three shots].

Women thus drank to relieve their feelings of helplessness, powerlessness, and lack of self-esteem in the face of stressful life events such as marital problems and loneliness. In explaining why some women drank, one respondent said it was because women think too much:

- r: "Oh yes! They [women] drink, some are caused by thinking too much, because some people say that when they drink like that, they don't think again.
 i: But the moment you become sober, all your problems will be waiting for you?
 r: Yes, that's why they drink more when they're becoming sober.

This respondent added that other women drank because alcohol was cheap or was served free at funerals:

- i: I also heard that during wake-keeping, at funerals, they drink a lot?
 r: Yes, they drink a lot, that is why so many people attend funerals, because of 'akpeteshi' [local gin], they are going to drink cheap 'akpeteshi.'

Another woman explained that some women drank because they worried too much about their financial problems, and believed alcohol would help them to forget about their problems:

Some drink for fun, but some drink because they worry. Just like the men, they think that by drinking then they will forget about their problems, so they keep on drinking until they become alcoholics Problems. And all, most hinges on money, financial problems (int. 18:24).

According to one of the other women the reason some women depended on alcohol was the belief that it was the only way to forget about one's numerous problems:

Many of them say that if you have a problem, and you're always thinking about it, the only way to forget about it is to drink. When you get drunk, you won't think about your problem again (int. 39:10-11).

Alcohol consumption, regarded by the women as another form of self-medication, may be more prevalent than the women were willing to admit. My frequent visits to a bar owned by one of my respondents and the observations I made there about the number of women who frequented this bar provided strong evidence of this assertion. On many occasions I saw women come in to either drink a few shots of the local gin or to buy some in bottles, conceal them under their clothes and take them home. Most often the older women came in on their own to drink and the younger women were accompanied by men. Following from my own observation and women's own accounts, it appears that the stress of multiple responsibilities on women is likely to increase their susceptibility to alcohol use. This would seem so because the more women felt that they could not cope, the more alcohol they consumed to divert their attention away from the reality of their life. It would seem that within their own circles Kpando women have accepted alcohol as a legitimate coping or problem solving mechanism.

SOCIAL SUPPORT

Another means by which women coped with their problems was by relying on family members, friends and neighbours. One characteristic of Kpando which makes social support easy to obtain is its communal way of living. In Kpando almost everybody is related to

everybody else, or knows everybody. A new person in town is immediately spotted. News spreads not through the media, but by word of mouth. The stable nature of the community contributed to this communal feeling. Many women lived with other family members on the same compound. They borrowed salt, pepper and other things from each other. Special meals such as rice and chicken were usually shared among relatives and neighbours. So, despite the conflicts noted in the previous chapters, family and neighbours were potential sources of social support for those women who needed it.

Many of my own experiences in Kpando attest to the benefits of the communal nature of Kpando life. During my stay in Kpando it was common for neighbours and friends to borrow various items from me, out of curiosity and assuming I would have whatever they needed because I had just come from abroad. In turn I felt free to borrow items from them. I was constantly given advice by neighbours, friends and sometimes people that I did not even know. One incident that stands out well in my mind and made a great impression on me was when I was awakened by a neighbour one morning. He said my neighbours had become worried when by 8.30 a.m. I had still not appeared, he had decided to come to check up on me to make sure that I was okay. My neighbours knew I was usually up by 6 a.m., but on that particular day I was late because I had conducted interviews late into the previous night. Although the practice of checking on neighbours is common in Ghana, the incident further developed my sense of belonging and reinforced my sense of security in the community. In

fact it made me feel so much at home that I understood all the more how women could use such communal networks to deal with their day-to-day problems.

Social support came in different forms in Kpando. Most often, it came in the form of emotional and sometimes financial support, especially from other women. A woman who had no job and very little financial help from her husband said she was able to feed her family by buying food on credit from her friends in the market:

When the 'chop money' [money usually given by husbands for the maintenance of the household] finishes, for corn dough for instance, there is a woman in the market who gives it to me on credit. When he [husband] gives me money again, then I go and pay my debts (int. 7:4).

She also confided in her friend about her marital and financial problems. She said on the days when she did not have anything to give her children her friend often gave her food to cook for her children. One of my respondents further pointed out that talking with her friends about her problems was comforting because it made her aware of the fact that her problems were not unique:

I get somebody to talk to, we sit down and converse, and talk about our problems. You'll see that you won't be thinking. Somebody tells you that she also has similar problems. I feel that I'm not the only person who has problems, then I'll find some comfort in that (int. 17:9).

Many women narrated instances where family and friends supported them in their times of need. One woman talked about how her mother came to her aid when her husband left her and their four children without telling her he had divorced her. Her mother not only

took over looking after her children, she also gave her job to her daughter to enable her to earn some income and thus help to pay for the care of her children:

Like this husband of mine, he has not told me that he has divorced me too, he just left me behind with four children. Where can I get money to feed them? ... So my mother came for my children and brought them to Kpando. I went to Kpalime [a town in Togo] to trade ... I was there hoping that my husband will come, my husband was not coming to visit, the children were also growing.... My mother sent a message to me that I should come back. When I went home she told me that my children are growing, the first born was going to secondary school, and she could no longer cater for all his school needs. By then my mother was working in Bishop Herman Secondary School. She advised me to take over her job so that I can work to help look after the children (int. 67:2).

Grandmothers are essential providers of childcare in Ghana. It is often their responsibility to take care of newborn grandchildren. It is quite common for elderly women in particular to live permanently with their married daughters or sons and take care of their grandchildren while their children work. In times of divorce or separation too, grandmothers perform important functions. They usually become the custodians of the children of the divorced parents.

Another woman explained that her mother had supported her through some difficult periods in her life. She had married for the second time and had her second child through a Caesarean operation. Her relationship with her second husband became sour immediately after the birth of their son. To make things even worse her baby's crib was set on fire twice by an unknown person. Although her baby was saved, she lost a lot of her property in the

fire. She said that had it not been for the emotional support she received from her mother she would have gone mad:

I hadn't recovered from my caesarean operation, my poor condition coupled with what happened [the fire], in fact, it really hurt me. The whole thing was um __ I don't know how to put it, in fact if it hadn't been for my mum who was with me, I would have gone mad (int. 74:8).

Another woman who lived with her mother explained that she confided in her mother when she was troubled about an issue:

My mother, because I wouldn't like anybody outside to know what is happening to me, so I tell my 'old lady' [mother] It's only me and my 'old lady' who discuss our problems (int. 34:12).

One woman said that she had been very depressed when her daughter had died leaving behind two children, one of them just a few months old. She said she found comfort, however, from friends, neighbours and the spirits of her dead daughter:

My granddaughter came to live with me when my daughter died. I even breast fed her for a long time, because she was still breast feeding when she died... I kept on thinking and lamenting ... but people who came to visit talked to me and comforted me. Later on she [the dead daughter] sent me a message [through a dream] ⁶ that 'I had made mounds, and had put yam inside them, the yam got rotten, but the seed for the planting is the one in my hand [that is the granddaughter that she was nursing], so I should take it and take good care of it.' After that, I just felt comforted (int. 62:1).

Another woman who said she had become fed up with her husband's womanizing behaviour and was considering leaving him explained how her landlady came in persistently to console her and advise her to be patient:

Like my husband, at first when I knew him he liked women, this made me worry a lot. Before I had my first child, if it wasn't for the landlady of our house who talked to me, I nearly left him. Because he was bothering me with other women to the extent that I couldn't take it any more, even food, I couldn't even eat again. I became very thin, you'll think I was about to die, so I decided to leave. But this woman [her landlady] talked to me, she kept on talking to me, so I decided to stay (int. 39:4).

Although many women found it difficult to divorce their husbands a few said they were able to leave their husbands when they could no longer tolerate them. Many of the women who were able to do this seemed to have support from relatives because they usually returned to their family homes. This was the case of one of my respondents. She was an elderly woman who explained that she left her husband when she could no longer tolerate his irresponsibility:

My marriage! The man didn't care about me at all. He didn't even consider the fact that I was giving birth to his children, so he should look after me, or the children, their clothing, their food, their welfare. I was the one doing everything. So I decided to leave him, because I was suffering too much (int. 71:2).

The woman went on to describe her second marriage which she said was similar to the first. Her new husband also gave her little financial help to take care of the household. She explained that to make things worse, the man did not seem to appreciate her efforts. She thus became fed up with the man and left him:

This marriage was the same, there was 'tukara' in this one too. I had to make my own farm, I had to look for food myself, I had to go to the market, buy fish and food for the house. I was looking after my husband and my children, and the man was not appreciating what I was doing. The least thing, he becomes offended, sometimes he'll give me money for the market,

maybe 100 or 200 Cedis [about 30 Cents]. But when I take my foodstuffs to the market, I get about 3,000 [CAN \$4.30] By the time I finish buying soap, kerosene and all that, the money is already finished. I looked at the whole situation, I didn't like it, so I left and came back home (int. 71:2).

Following society's way of thinking many women considered divorce to be an indication of their own failures as obedient and submissive wives to their husbands. Women who managed to leave their marital homes to live by themselves continued to be regarded as wives to their former husbands by the men they had left and by other members of the society. The situation many women encountered would therefore seem to be one from which they could find no easy channel of escape and this made their lives all the more stressful. Social support especially in the form of emotional support from family, friends and neighbours becomes very important to women in these circumstances.

The discussion in this chapter points to the fact that women did not give up in the face of their troubles but rather took action on their health problems. They tried to find different ways to offset or cope with the problems they encountered in their day-to-day lives. The women mentioned that they relied on different forms of western and traditional medications; they treated their own ailments and obtained their supply of medicines from pharmacy shops and medicine peddlers. Due to the indispensable nature of their responsibilities they relied heavily on painkillers to enable them to keep going. Women also used alcohol and religion to cope with the stresses and strains in their lives. Finally, family members, friends and neighbours were important sources of support for the women I

interviewed. Some of the methods women adopted may be perceived as unhealthy or even dangerous to their well-being but to them any coping strategy was better than doing nothing at all about their problems. The fact that women were willing to go to great lengths to ensure that they remained strong in order to support their families tells us about their resilience and also about their resourcefulness, creativity and willingness to fight. Far from being the helpless victims, the women of Kpando stand up to the difficulties of their day-to-day lives. In the next section, I focus on women's suggestions for improving the conditions of their lives. These are ways in which they adopted a broader perspective and considered the importance of policy changes in the future.

SUGGESTIONS FOR CHANGE

The women made a number of suggestions about how to improve their health conditions. These ranged from access to health care, to education, to credit for trading activities. For the most part their suggestions were sociocultural in nature. While they addressed their immediate problems through medication, alcohol and religion - that are individualistic - they did see the social roots of the problems they encountered. I begin with a quote which captures what women felt could be changed:

They [government] should take care of our health. So that we will be healthy, so that the little money we get, we won't spend it on hospital fees. Also they must get us more income-generating activities, so that we will have something to do, because financial problems are the main problem, it is what causes us to think a lot. So if we get something that will be giving

us some money for our daily bread, I think things will be better ...
Unemployment is a big problem here, so we need jobs (int. 70:11-12).

The women's suggestions for change in their health conditions focused more on prevention than cure. They believed that by changing the sociocultural conditions under which they lived, the quality of their lives would improve. Although some of their suggestions pointed to a direct change or improvement in the health care system, most of the suggestions were social in nature. They stressed the need for jobs to enable them to generate their own incomes. They also suggested that for those who were interested in establishing their own businesses, the government could help by giving them loans. They further suggested that their children be given educational opportunities so that their children's life chances would be better than their own.

Better Medical Care

Almost all the women complained about the high cost of medical care and thus suggested a reduction in hospital fees; the present cost of medical treatment was beyond their means. A single mother of three explained that because of the high fees, she was unable to send her children to the hospital whenever they were ill and was thus forced to rely on the pharmacy shops for diagnoses and medication:

The thing is that, we women these days, taking care of children and the numerous work we do. Me for example, I don't have any money, I'm always broke, so that if today, my child should fall ill, the only thing I can do is to go to the drugstore and combine some tablets for her. Because if I should

send her to the hospital, they'll ask me to pay 3,000 [Cedis, about \$CAN \$4.30], but when I enter my room right now, I don't have that much. So they should help us, medicine and hospital fees should not be expensive, they should reduce these fees so that we can also go to the hospital (int. 13:9).

Another woman who said she suffered from hypertension explained that high hospital fees had forced her to refuse admission to the hospital for supervised treatment. She could not afford the cost of being admitted to the hospital and expressed concern about how she was going to take care of herself and who she could turn to for assistance if she were to be admitted:

Like the last time I went to hospital and they asked me for 10,000 [about CAN \$14.30], I thought about that too, before thinking about who will be taking care of me while I was in hospital ⁷, so it's money (int. 66: 13).

The women who were employed suggested that their employers should share the cost when they went to the hospital for medical checkups. Many of them explained that despite the fact that they worked under deplorable conditions, their employers were unwilling to pay their medical bills. A woman who worked as a cook in a secondary school explained that the workers were not able to seek immediate medical attention and as a result were usually overcome by their illnesses because of lack of money.

Sometimes you will be ill, but you can't afford to go to the hospital, because the moment you collect your pay, you just distribute it to your debtors and then it gets finished. So you just continue to be sick. Maybe if you should get the chance to go to the hospital at once, the illness will not overcome you like that (int. 29:9).

She thus suggested that employers (in her case, the government) should help workers seek immediate medical attention by paying their medical bills:

The government should try and see to our welfare, although we have not been to school, we are working, we are performing a function, they should see to our welfare, we need to survive before we can work... Our health is very important. They say the government is supposed to take care of our health, but when we go to the hospital and bring the bill, it will be there, they won't refund us the money (int. 29:10).

Education and Job Creation: Jobs = Health

Many women, especially those who had some education, believed in the importance of education and emphasized the need for it. Women felt their education should be geared towards finding permanent and well paying jobs. A teacher said the only way women could find such employment was to attain the highest level of education. A 31-year-old store accounts clerk whose education had ended after high school expressed her longing to go back to school to pass her high school examination and then proceed to a nursing training college. She believed that with better education, women would be qualified for better jobs and thus earn more money and respect from their partners:

I'll say they should help me financially so that I can go back to school, because if we are educated, we will be able to get good jobs and can look after ourselves, and the men will also not play us, like balls, they won't disrespect us. So I think good education is important (int. 69:8).

The importance of education was emphasized by another woman who was a trader. She explained that education enabled women to do better accounting and as a result become

better businesswomen. To her the root of women's problems was poverty. In order to stop "thinking too much" and to be happy, women must find ways to earn sufficient incomes by becoming better educated:

If the government wants to reduce our 'tukara,' then the first thing is to be educated. If we are literate, then if it [government] gives us money, that is a loan, you can trade with it and do good accounting, and you won't go bankrupt, and be successful ... Then we women will also be happy, then the thinking will also reduce, because it is the poverty that is causing the thinking and the unhappiness (int. 66:13).

Most women equated well paying jobs with health. They believed that having a job was the only means to good health. An unemployed woman established this link when she explained how her bodily pains were caused by her persistent worry about her unemployed status:

My health, right now I'm unemployed, and the fact that I worry about it a lot, has turned into bodily pains for me. So I'm not sick, but I'm sick. Until I get a job, I won't feel healthy. So all the time my body is paining me (int. 67:8).

This woman further argued that being employed added to one's dignity as a human being. In an earlier conversation she had told to me how she was involved with a man who had promised to give her some money to trade. She said the man had still not fulfilled his promise. She explained that she felt helpless because of her unemployed status. She argued that if she had a job she would not have to worry about having a partner any more because she would be so involved in it that her job would symbolically become her husband. She

expressed her feelings about being unemployed with the following Ewe expression: "edor enye amegbetor" - to be human is to have a livelihood or job:

Now, I worry about my job, if I get a job, I won't worry about anything else, even marriage. I wouldn't care because "edor enye amegbetor" [to be human is to have a livelihood]. Your job becomes your husband, when you go and come back, you find a place to sleep, you wake up, you are gone again. You won't even worry about men. As for me that is what I think (int. 67:6).

Thus having a job was a source of dignity, power and independence for many women.

Another woman made a similar point about the respect that employment brings to women. She explained that when women become financially independent, they do not have to ask their husbands for money for such basic needs as underwear. She argued that if all women had jobs and earned money by themselves their husbands would have some respect for them:

Women should be helped to work. If a woman is working, it helps a lot. So it is necessary for all women to work, so that when you wake up and you won't say that because my husband has not given me money, I don't have any money at all. If the man doesn't give you money you can't even buy panties. Women have to work, and then the man will also respect you (int. 6:11).

Other women reiterated the relationship between health and jobs by explaining that if women had jobs, they would stop thinking and worrying about their husband's irresponsible behaviours. A young mother of two who was unemployed expressed the view that if she had a job, she would focus only on the job:

If you have a job, and the job pays, even if the man is crushing you with a stone too, you won't care. If somebody is doing everything to you too, you

won't mind, you will only concentrate on your work. The worry and the thinking will stop (int. 19:9).

Another said jobs would bring unemployed women happiness and health. Their bodily pains, for instance, would stop:

We should get some jobs. If we are working, then there will be happiness at home, then our bodies will be clear [healthy]. You see, as I was saying, unemployment gives bodily pains (int. 67:10).

To many women, therefore, becoming educated and finding steady jobs with good and regular incomes were critical life goals. Jobs were seen to produce dignity and respect. Employment would also provide women with a sense of some purpose in life and keep them very busy. Regular jobs would also enable women to meet other people and to enjoy a social life outside the home. Most importantly, the women indicated that permanent jobs would give them financial independence, enable them to take better care of their households and help them stop thinking or worrying too much and thus improve their health. To many of the women therefore, good health was inextricably intertwined with employment.

Loans for Business

Most of the traders interviewed suggested that since lack of money was at the root of many of their problems, they should be given loans to assist with their trade. One woman emphasized the crucial need for money to trade: "Money is the key to everything in our society..." (int. 18:7). Another woman explained: "Because money is at the root of

everything, money makes everything possible, you see, so government should help” (int.

33:6). A trader commented:

And everything depends on money. If you have money, you wouldn't have to think too much. For example if I had some money to sell something else, would I be running around plantain farms collecting leaves to do this work by all means? So money, money is the problem (int. 50:10).

Another trader explained how important money was to women's health by saying that her poverty was the reason she always had to bear the ordeal of carrying heavy loads even when she was experiencing bodily pains:

Sometimes things that you're not supposed to do, you're forced to do them. You wake up and ask yourself, what am I going to do today? What are we going to eat today? So because of need, poverty, you'll be experiencing a lot of pain, but you have to keep on working. All these are the pains we experience. But if you have money, you'll be happy. If you're a trader, and you have money, whatever you want, you can get, whatever you want to eat, you'll eat. But look at me, I'm experiencing a lot of pain right now, my whole body is aching, but if somebody comes to me right now and asks me to carry a heavy load from here to the market for her for money, it's not safe for me to do it, but because of poverty, I'll do it. These are the pains we experience (int. 41:7).

Many women said they had dreams of owning their own small businesses but this was not possible because of their lack of money. Women suggested that the government should help them with loans to enable them to achieve this dream. They explained that owning their own businesses would reduce their financial burdens reduce their "thinking too much" and ultimately make them healthy: “I will tell Rawlings [the president of Ghana] to give me money to trade, then I will stop making too much 'tukara' and my health will also

be okay” (int. 57:7). A typist suggested an improvement in women's incomes. She said this would enable women to save some money to use as capital to engage in other income-generating activities: “They should improve upon our salary, so that some of us can do some trading in addition to what we are doing. As for now, it's not easy at all” (int. 8:7). She further explained that higher incomes would ultimately result in the improvement of women's general health status:

If the money is okay, then our food will become better, and then you won't be thinking too much, and then you won't fall ill to the extent of going to the hospital (int. 8:7).

Another woman suggested that in owning their own businesses women would be in a better position to take care of their children: “They can give us loans, they should help us to make money and take care of our children, so that their future will be better than ours” (int. 56:9).

A trader narrated the following episode to show how vulnerable those who do not have capital for trade are:

Last market day, I bought 7,000 Cedis [CAN \$10] worth of dough, and I sold all the cassava dough 7,000 Cedis! But I didn't get even 200 Cedis [about 30 cents]. I didn't get any money, I even owed the seller 400 Cedis [60 cents], and the woman whom I owed was not a tolerant person, so she seized the bowl in which I sell the cassava dough ... the enamel bowl that I was carrying, the only one I have for fetching water, she seized it! ... Everybody begged her on my behalf, but she refused... she refused ooh! (int. 41:2).

The women said they were often at the mercy of the "big" businesspeople who lent them money at very high interest rates:

Last time, I went to Torkor to buy fish 6,000 [CAN \$9], on credit, the person told me that she will charge me 200 Cedis [about 30 cents] on every 1,000 Cedis [about CAN \$2]. Every market day, whether you were able to get fish or not, you have to pay, until you finish paying your debt. One market day, one of my sisters was sick, so I couldn't go to the market. Just one market day, before then I had sent her [the lender] 2,500 [about CAN \$4]. She came to meet me the next Sunday. She asked me if that is how we Ewes are, she insulted me very well. So it's not easy at all. Sometimes I go to Torkor, I don't get any fish, so if you go for that kind of money, how would you pay back? So these are some of the 'tukara'__ and by all means, I want to put food on the table for my children (int. 45:4).

Women also complained that they had no access to the little government money that came into the community to different organizations which was intended to be given out in the form of loans especially to women. Some of them explained that much of this money ended up in the hands of the more powerful women such as the Market Queen Mothers and big businesswomen:

They deceive us all the time. They tell us to get organized, we do that but we don't get anything. Nothing ... I remembered they told us the market women that they were coming to give us loans, we all gathered at Town Council, danced "borborbor" [traditional drumming and dancing] for a long time until we got tired. Up till now, nothing. Sometimes even when some money comes, they don't even consider some of us. Those who are older, the queen mothers and those kinds of people, they alone will share the money. Those of us suffering will continue to suffer, and those who are rich continue to be rich (int. 24:6).

Capital was a major problem for most traders. Apart from a few rich market women, women could not buy goods in large quantities for retail. They were forced to sell small quantities of goods which left them with little or sometimes no profit. In some cases, they had no capital and were forced to sell on a commission basis for the Market Queen Mothers who

often paid them very little money. It was thus not surprising that most women suggested that the government assist them by granting them loans.

In sum, women thought that a number of changes could be made to improve their lives. Women suggested that they needed an accessible health care system. They also felt that in order for them to get better paying jobs they needed to be better educated. They thus suggested that women be provided with more opportunities for education while at the same time the government create more jobs for women. Most of the traders said they needed loans to trade or establish their own businesses. The suggestions for change made by the women further point to the fact that women believe that their health problems are socially produced.

CONCLUSION

In this chapter I have analyzed the various ways in which women in this study said they coped with their health problems. The chapter has shown that in order to be able to sustain their families, women resort to various forms of medication, relying on both modern and traditional medicines. Most of them self medicated, turning to local pharmacists and vendors for their supply of drugs. Participating in religious activities and using alcohol were other ways women coped with the stresses and strains in their lives. Some women also depended on friends and relatives for financial and emotional support. In considering how their situations could be changed, women suggested improvements in the health care system,

education and employment. They also felt that they could be better businesswomen if they had access to credit from the government.

One main observation made here is that while women believed the sources of their problems varied, they felt that the material and social conditions within which they lived were at the root of their difficulties. They mostly relied on individualistic and short term methods of coping and these strategies enabled them to continue with their day-to-day activities without much disruption of the household routine. In making suggestions for change, however, they pointed to the social roots of the problems that they encountered in their lives and suggested more fundamental enduring solutions to them.

NOTES

1. "Indocid" or "Indocine" is the common name for this medicine among Ghanaians. Pharmaceutically however, it is known as "Indomethacin." It is an anti-inflammatory agent especially for the joints which acts as a painkiller.
2. Roasted dry corn (sometimes mixed with roasted peanuts) is regarded as food commonly eaten by the poor in Ghanaian society.
3. "Lorry Parks" are places where public transports are taken. These transports are usually owned by private citizens.
4. As it is the normal practice for prostitutes in Ghana to carry on their activities in and around hotels, hotels have generally been identified with prostitution. People who reside in hotels often risk being suspected of engaging in prostitution. Any woman who rents a hotel room is suspected of providing sexual services to male clients whilst men are normally suspected of soliciting the services of prostitutes. This explains the controversy surrounding the women's field trip.
5. In many Ghanaian societies drinking alcohol is considered to be a "man thing." It is regarded as unwomanly for women to drink alcohol. Generally women who drink alcohol, but especially those who drink to excess, are regarded as rather reckless, undisciplined and morally lax and are often severely rebuked. This explains the reluctance of many women to talk openly about their drinking habits.
6. In Ghanaian societies there is a strong belief in life after death. It is also believed that the "living dead" communicate with their living relatives and friends through dreams.
7. Many hospitals do not provide water and food to their patients. Water for bathing and drinking, food, fresh clothes and anything else that a sick person may need while in the hospital would have to be provided by relatives, friends and neighbours.

CHAPTER 9: CONCLUSION

This study has focused on Ghanaian women's health problems and concerns. It has shown how the health status of the women I interviewed is shaped by their day-to-day lives. The research has demonstrated ways in which women's roles expose them to conditions that are illness producing. The study also examines how women in Ghana are trying to deal with the challenges they face. The data attest to women's resourcefulness, creativity, inventiveness and determination to survive despite the obstacles they encounter. The accounts of the women in this study provide us with insights which challenge some of the commonly held assumptions about women in developing countries.

But the study goes beyond substantive questions about the daily hassles and health status of Ghanaian women. Underlying the main themes are important theoretical, methodological, and policy implications. In this concluding chapter I try to assemble the seams of my arguments on these broader questions concerning the health of women in Ghana and in developing countries generally. In other words I try to tie together the threads of the arguments I have made.

This thesis demonstrates the value of placing the voices of women at the centre of our analyses. As we see from the foregoing chapters, when women are given the opportunity to

tell their own stories, reveal their health problems and identify the causes of their ill health, a picture emerges that is somewhat different from the one experts, researchers and policy makers paint. When women's voices are central we are provided with a basis for comparisons between the existing data and the reality from women's point of view. In this study we see that, contrary to the emphasis in the literature, reproductive health problems are not the only or the main health problems of women in developing countries. Women in this study experienced psychosocial health problems and physical health problems such as headache, bodily pains, tiredness, fever and weakness. Reproductive health problems such as miscarriage, irregular periods and menopause, were the least frequently reported ailments.

Biological reproductive health problems such as pregnancy and childbirth were not even at the fore of women's worries about their health. The women in this study said they were more concerned about AIDS and venereal diseases. While the health problems they experienced were low level in nature, their worries about their health focused more on life threatening conditions. In addition to AIDS and sexually transmitted diseases, they were concerned about hypertension, cancer and heart diseases. This picture of women's experienced health problems and women's health concerns is absent in much of the literature on women's health status in the developing world. This again brings into focus the importance of women's own definitions, perspectives and priorities.

Mental health has received relatively little attention in discussions of women's health in developing countries. We know very little about the prevalence of mental illness among

women in developing countries or the factors which contribute to their poor mental health. The accounts of women in this study reveal considerable low level mental health problems. Most of the women spoke about "thinking too much" or "worrying too much." This was, in turn, linked with headaches and sleeplessness. They also described certain unusual behaviours such as "talking into the air", or "throwing hands into the air", walking without knowing where one was going, or "tying one yam." They attributed many of these behaviours to the stresses and strains caused by their financial problems, their heavy work loads, the misbehaviour of children, the conflicts they had with their husbands and other life situations from which they could not easily disengage. For some women these problems had developed a chronic character.

Scholars often focus on psychiatric disorders such as schizophrenia and gloss over more subtle demonstrations of the psychosocial health problems of women. Women are thus left to suffer quietly or even to accept these problems as part and parcel of their lives. One contribution of this study is that it sheds some light on the less obvious ways in which women's poor mental health manifests itself. For the women I interviewed, preoccupation with "thinking too much," as well as unusual behavioural traits were signs of their impaired mental well-being. This suggests that in our research on the mental health of women we need to define the problem in broader terms to include low level psychosocial health problems. It also indicates that we need to look beyond hospital records and biological explanations of mental illness in documenting the state of women's mental well-being.

This study also surfaces some of the difficulties one encounters presenting women's own views in a language other than the indigenous one. We encounter problems in adequately representing the indigenous terms women use to describe the realities of their day-to-day lives. As we do not always have English equivalents of indigenous concepts, we often face difficulties in representing the exact views of women. As Lugones and Spelman (1986:22) have pointed out, the use of language is important in methodology and the use of borrowed language could distort images or inhibit the ability to communicate real experiences. Thus, even though we may say that the voices of ordinary women need to be heard in our analyses, we have yet to determine how to do this so that our non-native readers not only hear but also understand these women on their own terms. The many endnotes and square brackets explaining indigenous terms and local expressions in this study demonstrate some of the problems encountered in doing this.

A number of themes have emerged from this study which raise issues of theoretical importance. At the fore is the question of how adequately existing conceptual models reflect the totality of women's lives and their health. Conventional approaches have often explained women's health and illness from a biomedical or cultural-behavioural perspective. This has resulted in biological and individualistic explanations of women's ailments. Health problems have been understood in terms of the internal workings of women's bodies or their behaviour or cultural practices. The result has been a partial picture of the factors which determine women's health. Although these perspectives have helped in identifying and treating many

illnesses in women, they are narrow insofar as they do not take into account the wider environment within which women live.

The findings of this dissertation have not only raised questions about the adequacy of these prevailing theoretical perspectives, they also point to the advantages of placing women's health in a broader context, highlighting how the conditions under which women live and what they do every day determines their well-being. Women's health problems are more complex and broader than is generally thought. The women interviewed in this study explained their health status in terms of how they live their lives. They understood their health problems within the broader social contexts of their daily work activities, the structures that determine their lives, their relationships with partners and other women and the conditions in their households. Biomedical and cultural-behavioural explanations of ill health have tended to emphasize the individual and in the developed world this has led to a very strong emphasis on individual responsibility for health - an emphasis which can readily "blame the victim." It is interesting that the women in this study did not blame themselves or see themselves as the source of their ill health. In contrast to the situation in many developed countries, Ghanaian culture does not appear to encourage this sense of individual responsibility or self-blame. They did not consider it to be their fault that they were ill. Rather, they said that the social conditions under which they lived and the activities they had to engage in every day to sustain themselves and their families made them ill.

The views of women expressed within this study do not show much evidence of their being medicalized. The women did not construct their health and illness in biological or medical terms and they did not borrow from the language of biomedicine. Although they relied on both western and traditional medication or a mixture of these in coping with their ailments, women regarded medication only as a means to an immediate end and they did not rely on physicians. Medication helped them to manage and to meet their day-to-day obligations. They said the causes of their health problems were broader and social in nature. Again, this presents a contrast to the situation in western societies where medicalization is said to have engulfed women's explanations of their health (Miles, 1991:48; Oakley, 1984; Penfold and Walker, 1983). Indeed, the issue of whether or not women are medicalized may represent a westernized point of view.

Related to the issue of the lack of medicalization is a common assumption, especially held by African scholars, that supernatural explanations predominate in people's explanations of illness in African societies. Witchcraft, sorcery, the evil eye and other supernatural agents have been identified (Fayorsey-Mantey, 1988; Nukunya and Twumasi, 1978) as the common explanations women in developing countries use to understand the causes of illnesses. The explanations offered by women in this study throw this perspective on supernatural causation into question. Women's explanations of the causes of their health problems tended to emphasize the social and material conditions of their lives. The present study thus questions

the extent to which previous research adequately reflects women's own perspectives on the causes of their ill health.

The thesis raises other issues of theoretical and substantive value concerning the social production of illness. Women pointed to the fact that the essence of being a woman was in itself illness producing. Gender shapes women's lives and health status, and to understand this, it is important to examine women's roles in biological and social reproduction and production. Women's health is affected by their biological reproductive roles. The fertility rate of women in Ghana is high and exposes them to numerous health problems related to reproduction. Moreover, frequent births increase the heavy domestic and productive activities that women must undertake and this exposes them to even more health risks; larger families create more work for women.

In this study, women's roles in social reproduction, which involves the care and maintenance of the household (Momsen, 1991:28) was identified as an important determinant of health. Women's activities in this respect include household activities such as fuelwood and water collection, cleaning and washing clothes. Women are also responsible for processing, preparing and cooking food for the household. Women care for the sick and the elderly. In many instances, they play important functions in the education of young children. These gender roles and the expectations associated with maintaining a household, which the women I interviewed described as "tukara," are tiring and time consuming and predispose women to illness.

In addition to their social reproduction activities, women's productive activities were also viewed as important factors in their ill health. One gathers from this study a clear sense of Ghanaian women's high level of productivity. Work is very central to these women's lives, as they have to work to ensure the maintenance of their families. Almost all the women said they engaged in some form of income-generating activity either to supplement the household income or to take sole responsibility for their families. Many of them engaged in multiple work activities to be able to "make ends meet." They often farmed, traded and worked in offices at the same time. Their work involved long periods in the sun or rain, walking for long distances, and monotonous or repetitive activities. This work has often remained invisible in discussions of women's health. The versatility of the women in this study shows that women deserve greater recognition and a more positive appraisal of their work roles in and outside their homes.

This study also confirms the argument that the line between production and reproduction is sometimes blurred in the developing world (Brydon and Chant, 1989:11). In many cases both kinds of activities take place in the same environment and at the same time. Although women's activities may take place in the domestic sphere, many of these activities are productive because they generate income or enable savings. Many of the women I interviewed, for instance, looked for their own fuel or reared animals in order to save money that would otherwise be spent on such items. Some of them farmed and sold part of their farm produce for cash. Women who sold food fed their families on part of the food they

cooked for sale. These examples show that we cannot easily distinguish between the productive and reproductive work of women in developing countries. These conventional distinctions can be quite inadequate in specific situations and we need to be cautious in our application of them.

Institutional sources of social support for the women interviewed for this study were limited. Ghanaian women lack many resources such as credit, daycare facilities and organized support networks. To be able to perform their roles as wives, mothers, caregivers and workers, women rely on coping methods such as modern and traditional medicine, alcohol and religion. Support from relatives and friends was also an important means of coping with problems. Women relied on relatives and friends for childcare and childrearing. They also turned to them for financial assistance and emotional support. But the pressures of urbanization and changes in the economic conditions of people's lives are making it difficult for them to offer support to one another. Women's approaches to coping may not necessarily be healthy, but they enable them to function on a day-to-day basis.

As this dissertation has shown, although social relationships are important to women, they are frequently characterized by tension and conflict. Even though women derived support from family and friends and from other members of their community, they faced a number of problems. Women's relationships with their partners, co-wives, mothers-in-law, children and other relatives often caused them stress. Women felt they did not always derive the companionship and emotional support they needed from their relationship with partners.

In situations where women lived with co-wives and in-laws and where they were not on good terms with one another the home environment could be all the more stressful. Domestic situations could be made much worse by problem children. Ideally, the home represents a safe environment and a place which offers support to those who live there. But for women in Ghana the idea that homes are places of safety and support is something of an illusion, because even in their homes conditions exist which expose women to illness.

The women interviewed for this research have started to question the gendered division of labour in Ghana. In a more broadly considered sense, their views indicate an emerging indigenous critique of existing social structures. Women increasingly expect men to do more to help them. They believe that men have to cross that gender barrier in the division of work because they themselves have already crossed it - for instance, by contributing financially to the maintenance of their households. While they expressed this opinion, at the same time they expressed a sense of being under pressure from the social expectation that they perform "women's" roles and much of their energy is still consumed in managing to "get by" from day to day.

One striking feature of the interviews I conducted was the ambivalent feelings women expressed about their partners or about relationships with men generally. On the one hand, women said the behaviour of their partners contributed to conditions that made them ill. Yet on the other hand, they expressed the sense that men were indispensable in their lives. They said they needed partners to demonstrate their worth as "women" according to the

expectations of their communities, to father their children and to provide company and emotional support. Such ambivalent feelings tell us a great deal about the tensions under which women live their lives in Ghana. While women in Ghana often feel severely pressured to marry, many of them are daunted by the realities of married life. Many women's married lives were characterized by insecurities since the possibility of being divorced or abandoned was high. There was also a lot of stress and tension between partners and sometimes with in-laws. In addition, married life involved heavy household and childcare responsibilities. From whichever angle one looks at their problems, women are never "free" in Ghana, a sentiment frequently expressed by the women I interviewed.

This dissertation has also brought to the forefront the precariousness of Ghanaian women's lives. Their lives have been shown to be unpredictable in many ways. There is no security in their relationships with men. The nature of their productive activities makes them vulnerable to many factors. For example, farmers are at the mercy of the seasons, while traders lack credit and are exposed to price fluctuations. In addition to the unreliability of their income sources most women also earned insufficient money to make a decent living. Social programs and policies such as SAP have also done little to reduce the precariousness of women's lives; in fact, SAP may well have jeopardized many women's incomes. The unpredictability of their relationships with men, their jobs, the prevailing economic conditions and social policies have all contributed to women's poor health status.

Another aspect of women's lives has emerged in this analysis - their strength and resourcefulness. Although there are many barriers to their productive work, women are able to adopt a variety of methods to achieve their aims. Societal pressures, gender roles, difficult economic situations and government policies such as SAP have all worsened women's already poor social conditions, but women have not simply accepted their misfortune. The range of their skills and activities ensures that at each point in time they are able to find a means to sustain their households. To ensure the survival of their families many women sacrifice their own well-being. There were instances in the study where women described travelling for days to remote places to engage in trade under very difficult conditions, depriving themselves of food and other comforts to trade or buy goods for sale. One woman, for instance, was willing to relocate to a larger town (leaving her husband behind in the village) to search for a more lucrative way of making money as a trader because the couple could no longer survive on the proceeds from their farm. Many of the conditions under which women lived and worked were detrimental to their health but these conditions did not defeat them. Indeed, the images emerging from this study do not present Ghanaian women as powerless, dependent and weak people, a picture commonly presented of women in developing countries by both western scholars and scholars from the developing world. The women in this study are strong and determined women who found various ways of coping despite the barriers to their survival in Ghanaian society. They are heads of households and

even in situations where they live with their partners, many of them are solely responsible for the household, making important decisions and managing household activities.

This study has hinted at a number of themes and questions which could help direct future research on the health of women in the developing world. It questions the adequacy of traditional methods of conducting research in the developing world and it has also pointed to the need for a broader conceptualization of women's health. The research questions the adequacy of sources of data on women's health in developing countries and it has demonstrated that hospital-based records or mortality records are inadequate in terms of understanding women's health. Although these sources are very important, lay perspectives are also important and should no longer be ignored. Future research in the developing world must allow women's own views and priorities to emerge. The result will be a broader and more comprehensive approach to women's health. The women who experience these ailments are the best sources of information about how they experience health problems and how health problems are linked with the nature of women's lives. My study has shown that women are willing to talk about themselves when given the opportunity and the appropriate environment. Lay perspectives can thus be rich sources of information.

This research has also surfaced some unexplored areas in women's health. Women's health problems go well beyond reproductive health. We have seen that mental health is an important health issue for women, yet we know very little about the psychosocial health of women in developing countries. This is an area that needs further investigation. We need to

know the prevalence of mental health problems among women in different social and cultural settings. It is also important to better understand how women in developing countries perceive and construct their health. These research directions could lead to a much deeper understanding of women's health and illness in developing countries.

My study further prompts important questions concerning policy formulation and implementation: Who makes policies? Who implements them, and who benefits from them? Do the perceived concerns of policy makers reflect the priorities of those supposed to benefit from the policies? If the documented health problems of women are biological reproductive health issues and women themselves regard their mental health to be important to them, then there is a disjunction between what is really needed and what is provided. This dissertation points to the importance of including sources of information other than professionals, those working for non-governmental organizations and leaders of women's organizations in formulating policies. There must be more cooperation between a variety of sources in the formulation and implementation of policies. Policies may be ineffective if the voice of ordinary women is ignored.

The cooperative approach to policy formulation and implementation may be difficult however since for the most part state policies in developing countries are shaped by international agencies. A case in point is the Structural Adjustment Program where it has become virtually mandatory for developing countries to implement SAP, even where the effects of the programs may be detrimental to the welfare of the most vulnerable in these

societies. This dissertation has provided evidence that to be effective, policies which are geared towards the improvement of women's health need to incorporate women's own indigenous models and suggestions for change. It is my view that if policies are to respond to the needs of those for whom they are implemented then they must propose remedies that draw on and develop the resources and strengths of the people. In the context of women's health policy, this means that women's input is critical to the development and implementation of policies that affect them. A question arises here, however. Since women spend so much time working, caring for their husbands and children and dealing with problems in their households, how much time do they have left to engage in political activities to influence policy? We cannot presume an easy answer to this question. There are, nevertheless, positive signs. Women are asking questions and criticizing the assumptions of existing structures, and as this study has shown, they are willing to talk about their problems. I am also impressed by their ability to articulate their problems in clear terms. At best we can say that raising the issues, giving power to women's voices and pointing to the untapped potential for women's perspectives to influence policy are first steps. This is what I hope this study has achieved.

BIBLIOGRAPHY

- Abu, K. (1983) "The Separateness of Spouses: Conjugal Resources in an Ashanti Town", in Oppong, C. (ed.) Female and Male in West Africa. London: Allen and Unwin, pp. 156-168.
- Adepoju, A. and Oppong, C. (1994) Gender, Work and Population in Sub-Saharan Africa. London: Heinemann.
- Afonja, S. (1990) "Changing Patterns of Gender Stratification in West Africa", in Tinker, I. (ed.) Persistent Inequalities: Women and World Development. New York: Oxford University Press, pp. 198-209.
- Afshar, H. (1987) "Introduction", in Afshar, H. (ed.) Women, State, and Ideology: Studies from Africa and Asia. USA: State University of New York Press.
- Afshar, H. (1987) "Women, Marriage and the State in Iran", in Afshar, H. (ed.) Women, State, and Ideology: Studies from Africa and Asia. USA: State University of New York Press, pp. 70-88.
- Afshar, H. (ed.). (1991) Women, Development and Survival in the Third World. London and New York: Longman.
- Afshar, H. and Dennis, C. (eds.) (1992) Women and Adjustment Policies in The Third World. New York: St. Martin's Press.

- Ahonsi, B. (1991) "Components of Stability: High Fertility in Three Areas of West Africa", Social Science and Medicine, Volume 33, Number 7, pp. 849-857.
- Agarwal, B. (1986) Cold Earth and Barren Slopes: Woodfuel Crisis in the Third World. California: Riverdale.
- Agarwal et al. (1990) Engendering Adjustment For the 1990s: Report of a Commonwealth Expert Group on Women and Structural Adjustment. London: Commonwealth Secretariate.
- Ampofo, D.A., Nicholas, D.D., Amoonu-Acquah, M.D., Ofosu-Amaah, S. and Newmann, A.K., (1977) "The Training of Traditional Birth Attendants in Ghana: Experience of the Danfa Rural Health Project", Tropical Geography and Medicine, Number 29, pp. 197-203.
- Ampofo, A. A. (1993) "Controlling and Punishing Women in Ghana", A Review of African Political Economy, Number 56, pp. 102-110.
- Anarfi, J. K. (1993) "Sexuality, Migration and AIDS in Ghana: A Socio-behavioural Study", in Health Transition Review, Supplement to Volume 3, pp. 45-59.
- Apesemah, N. P. (1987) "Some of the Psychological and Social Factors that Promote and Entrench Some Cultural Practices: A Case Study of Female Frafras of Upper East of Ghana", A Project Work Submitted to the Department of Psychology, University of Ghana, Legon, in Partial Fulfilment of the Requirements for the B.A. (Honours) Degree in Psychology. (Unpublished).

- Arber, S., Gilbert, N. and Dale, A. (1985) "Paid Employment and Women's Health: A Benefit or a Source of Role Strain?" Sociology of Health and Illness, Volume 7, Number 3, pp. 375-401.
- Ardayfio-Schandorf, E. (ed.) (1994) Family and Development in Ghana. Ghana: Ghana Universities Press.
- Ardayfio-Schandorf, E. (1994) "Household Headship and Women's Earning in Ghana", in Ardayfio-Schandorf, E. (ed.) Family and Development in Ghana. Ghana: Ghana Universities Press, pp. 30-47.
- Ardayfio-Schandorf, E. (1993) "Household Energy Supply and Women's Work in Ghana", in Momsen, J. H., and Kinnaird, V. (eds.) Different Places, Different Voices: Gender and Development in Africa, Asia and Latin America. London and New York: Routledge, pp. 15-29.
- Ardayfio-Schandorf E., and Kwafo-Akoto, K. (1990) Women in Ghana: An Annotated Bibliography. Ghana: Woeli Publishing Services.
- Armstrong, P. and Armstrong, H. (1984) The Double Ghetto: Canadian Women and their Segregated Work. (Revised Edition) Toronto: McClelland and Stewart.
- Asante-Darko, N. and Van der Geest, S. (1983) in C. Oppong (ed.) Female and Male in West Africa. London: Allen and Unwin, pp. 242-255.

- Assael, M. I., and Namboze, J. (1972) "Psychiatric Disturbances During Pregnancy in a Rural Group of African Women", Social Science and Medicine, Volume 6, pp. 387-395.
- Assimeng, M. (1989) Religion and Social Change: An Introduction to the Sociology of Religion. Ghana: Ghana Universities Press.
- Awusabo-Asare, K., Anarfi, J. K. and Agyeman, D. K. (1993) "Women's Control Over their Sexuality and the Spread of STDs and HIV/AIDS in Ghana", in Health Transition Review, Supplement to Volume 3, pp. 69-84.
- Barrett, H. and Browne, A. (1993) "The Impact of Labour Saving Devices on the Lives of Rural African Women: Grain Mills in the Gambia", in Momsen, J. H. and Kinnaird, V. (eds.) Different Places, Different Voices: Gender and Development in Africa, Asia and Latin America. London and New York: Routledge, pp. 52-62.
- Bassett, M. T. and Mhloyi, M. (1991) "Women and AIDS in Zimbabwe: The Making of an Epidemic", International Journal of Health Services, Volume 21, Number 1, pp. 143-156.
- Beneria, L. (ed.) (1982) Women and Development: The Sexual Division of Labour in Rural Societies. U.S.A: Praeger.
- Beneria, L. and Roldan, M. (1987) The Crossroads of Class and Gender: Industrial Homework, Subcontracting, the Household Dynamics in Mexico City. Chicago: University of Chicago Press.

- Benneh, G. (1994) "Family and Development in Ghana: an Overview", in Adayfio-Schandorf, E. (ed.) Family and Development in Ghana. Ghana: Ghana Universities Press, pp. 5-13.
- Benneh, G., Nabila, J., and Gyebi-Garbrah, B. (1988) "Twenty Years of Population Planning in Ghana", Population Impact Programme. Ghana: Legon.
- Bimal, K. P. (1993) "Maternal Mortality in Africa", in Social Science and Medicine, Volume 37, Number 6, pp. 745-752.
- Bleire, R. (1984) Science and Gender. New York: Pergamon.
- Bimal, K., P. (1993) "Maternal Mortality in Africa: 1980-87", Social Science and Medicine, Volume 37, Number 6, pp. 745-752.
- Blanc, A. K. and Lloyd, C. B. (1994) "Women's Work, Childbearing and Childrearing Over the Life Cycle in Ghana", in Adepoju, A. and Opong, C., (eds.) Gender, Work and Population in Sub-Saharan Africa. London: Heinemann, pp. 112-132.
- Blaxter, M. (1990) Health and Lifestyles. London: Routledge.
- Boerma, T. (1987) "The Magnitude of The Maternal Mortality Problem in Sub-Saharan Africa", Social Science and Medicine, Volume 24, Number 6, pp. 551-558.
- Boserup, E. (1970) Women's Role in Economic Development. New York: St. Martin's Press.
- Bourque, S. C. and Warren, K. B. (1990) "Access is Not Enough: Gender Perspectives on Technology and Education", in Tinker, I. (ed.) Persistent Inequalities: Women and World Development. New York: Oxford University Press, pp. 83-100.

- Brown, G. W. and Harris, T. (1978) Social Origins of Depression. London: Tavistock.
- Browner, C., H. (1989) "Women, Household and Health in Latin America", Social Science and Medicine, Volume 28, Number 5, pp. 461-473.
- Brydon, L. (1985) "The Dimensions of Subordination: A Case Study from Avatime, Ghana", in Afshar, H. (ed.) Women, Work, and Ideology in the Third World. London and New York: Tavistock.
- Brydon, L. and Chant, S. (1989) Women in the Third World: Gender Issues in Rural and Urban Areas. New Brunswick, New Jersey: Rutgers University Press.
- Bunch, C. and Carrillo, R. (1990) "Feminist Perspectives on Women and Development", in Tinker, I. (ed.) Persistent Inequalities: Women and World Development. New York: Oxford University Press, pp. 70-82.
- Busfield, J. (1986) Managing Madness: Changing Ideas and Practice. London: Hutchinson.
- Buvinic, M., Lycette, M. and McGreevy, W. (eds.) (1983) Women and Poverty in the Third World. Baltimore, MD: Johns Hopkins Press.
- Caldwell, J.C. (1993) "Health Transition: The Cultural, Social and Behavioural Determinants of health in the Third World", in Social Science and Medicine, Volume 36, Number 2, pp. 125-135.
- Calnan, M. (1988) "Lay Evaluation of Medicine and the Medical Pilot Study", International Journal of Health Services, Volume 18, pp. 311-322.

- Charles, N. (1993) Gender Divisions and Social Change. Great Britain: Harvester Wheastheaf.
- Charlton, S. E. M., Everett, J. and Staudt, K. (1989) "Women, the State, and Development", in Charlton, S. E. M., Everett, J. and Staudt, K. (eds.) Women, the State, and Development. USA: State University of New York Press, pp. 1-19.
- Cliff, J. (1991) "The War on Women in Mozambique: Health Consequences of South African Destabilization, Economic Crisis, and Structural Adjustment", in Turshen, M. (ed.) Women and Health in Africa. Treton, New Jersey: Africa World Press, pp. 15-35.
- Cutrufelli, M. R. (1983) Women of Africa: Roots of Oppression. London: Zed Press.
- Daddieh, C. K. (1989) "Production and Reproduction: Women and Agricultural Resurgence in Sub-Saharan Africa", in Parpart, J. L. (ed.) Women and Development in Africa: Comparative Perspectives. Lanham: University Press of America, pp. 165-194.
- Danquah, S. A. (1978) "Some Aspects of Mental Health of Ghanaian Women: Female Psychoneuroses and Social Problems" in Proceedings of the Seminar of Ghanaian Women in Development, Organized by the National Council on Women and Development, in Ardayfio-Schandorf, E. (ed.) Women in Ghana: An Annotated Bibliography. Ghana: Woeli Publications Services, Volume 2, pp. 810-822.

- Date-Bah, E. (1984) "Rural Women, Their Activities and Technology in Ghana: An Overview", in Rural Development and Women in Africa. International Labour Organization (ILO), Geneva.
- Dawson, J. (1964) "Urbanization and Mental Health in a West African Community", in Kiev, A. (ed.) Magic, Faith and Healing. New York: The Free Press, pp. 305-342.
- Dennis, C. (1987) "Women and the State in Nigeria: the Case of the Federal Military Government, 1984-5", in Afshar, H. (ed.) Women, State, and Ideology: Studies from Africa and Asia. USA: State University of New York Press, pp. 13-27.
- Dinan, C. (1983) "Sugar Daddies and Gold Diggers: The White-Collar Single Women in Accra", in Oppong, C. (ed.) Female and Male in West Africa. London: Allen and Unwin, pp. 344-366.
- Dolphyne, F. A. (1991) The Emancipation of Women: An African Perspective. Ghana: Ghana Universities Press.
- Doyal, L. (1995) What Makes Women Sick: Gender and the Political Economy of Health. London: Macmillan Press Limited.
- Doyal, L. (1983) "Women, Health and The Sexual Division of Labour: A Case Study of The Women's Health Movement in Britain", Critical Social Policy, Volume 7, pp. 21-33.
- Doyal, L. (1979) The Political Economy of Health. London: Pluto Press.

- Dutton, D. B. (1989) "Social Class, Health, and Illness", in Brown, P. (ed.) Perspectives in Medical Sociology. (Second Edition) California: Wadsworth Publishing Company, pp. 23-46.
- Dzakpasu, E. E. (1993) "Women's Economic Activities in a Family: A Sociological Study of Women in Kpando Town", A Dissertation Submitted to the Department of Sociology, University of Ghana, Legon in Partial Fulfilment of the Requirements for the Award of the Certificate of Prisons Administration. (Unpublished).
- Eades, C.A., Brace, C., Osei, L., LaGuardia, K.D. (1993) "Traditional Birth Attendants and Maternal Mortality in Ghana", Social Science and Medicine, Volume 36, Number 11, pp. 1503-1507.
- Ebie, J. C. (1972) "Some Observations on Depressive Illness in Nigerians Attending a Psychiatric Out-Patients Clinic", African Journal of Medical Science, in Rothblum and Cole (eds.), Women's Mental Health in Africa. New York: The Haworth Press, Volume 3, pp. 14-155.
- Eichler, M. (1980) The Double Standard: A Feminist Critique of Feminist Social Science. London: Croom Helm.
- Elabor-Idemudia, P. (1994) "Nigeria: Agricultural Exports and Compensatory Schemes - Rural Women's Production Resources and Quality of Life", in Sparr, P. (ed.) Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment. London: Zed Books, pp. 134-154.

- Elling, R. (1981) "Industrial and Occupational Health in Underdeveloped Countries", in Imperialism, Health and Medicine: Policy, Politics, Health and Medicine Series. New York: Baywood Publishing Incorporated, pp. 207-233.
- El-Mouelhy, M. T. (1990) "Family Planning and Maternal Health Care in Egypt", in Rothblum, E. D. and Cole, E. (eds.) Women's Mental Health in Africa. New York: The Haworth Press, pp. 55-60.
- Eyles, J. and Donovan, J. (1990) The Social Effects of Health Policy. Avebury: Aldershot.
- Fapohunda, E. R. (1983) "Female and Male Work Profiles", in Oppong, C. (ed.) Female and Male in West Africa. Allen and Unwin.
- Farhood, L., et al. (1993) "The Impact of War on the Physical and Mental Health of the Family: The Lebanese Experience", Social Science and Medicine, Volume 36, Number 12, pp. 1555-1567.
- Fayorsey-Mante, C. (1988) "The Ghanaian Woman's Perception of Disease and Sickness and Cultural Practices That Affect Maternal/Infant Child Morbidity and Mortality", Ghana: University of Ghana, Department of Sociology. (Unpublished).
- Finerman, R. D. (1988) "The Price of Power: Gender Roles and Stress - Induced Depression in Andean Ecuador," in Whelehan, P. et al., (eds.) Women and Health: Cross - Cultural Perspectives. Massachusetts: Bergen and Garvey Publishers Incorporated, pp. 153-169.

- Fortes, M., Steel, R. W. and Ady, P. (1949) "Ashanti Survey 1945-46: An Experiment in Social Research", Geographical Journal, Volume 110, Number 4-6, pp. 149-79.
- Fosu, G. B. (1986) "Fertility and Family Planning in Accra", Journal of Biosocial Science, Volume 18, Number 1, pp. 11- 22.
- Fosu, G. B. (1995) "Women's Orientation Toward Help-Seeking For Mental Disorders", Social Science and Medicine, Volume 40, Number 8, pp. 1029-1040.
- Freudenberg, N. (1989) "The Corporate Assault on Health" in Brown, P. (ed.) Perspectives in Medical Sociology, Belmont, California: Wadsworth Publishing Company, pp. 104-121.
- Ghana Living Standards Survey Statistical Abstract (1989) Washington, DC.
- Ghana Ministry of Health Document. (1990) "Family Planning and Primary Health Care (PHC) by Traditional Birth Attendants (TBAs)", Final Report, Operations Research Project, Between Ministry Of Health and Centre For Population and Family Health Columbia University. New York, USA.
- Ghana Statistical Service (1988) "Ghana Population and Health and Nutrition Survey", Accra.
- Ghana Statistical Service (1989) "Ghana Demographic and Health Survey", Accra: Ghana Statistical Service and Columbia Medical Institute for Resource Development/Macro Systems Incorporated.
- Government of Ghana (1988) Ministry of Fuel and Power, Accra.

- Graham, H. (1993) Hardship and Health in Women's Lives. London: Harvester Wheatsheaf.
- Graham, W. J. (1991) "Maternal Mortality: Levels and Trends, and Data Deficiencies", in Feachem, R.G. and Jamison, D.T. (eds.) Disease and Mortality in Sub-Saharan Africa. New York: Oxford University Press, pp. 101-116.
- Greenstreet, M. (1990) "Education and Reproductive Choices in Ghana: Gender Issues in Population Policy", in Development, Volume 1, pp. 40-47.
- Grotberg, E. H. (1990b) "Mental Health Aspects of Zar for Women in Sudan", in Rothblum, E. D. and Cole, E. (eds.) Women's Mental Health in Africa. New York: The Haworth Press, pp. 14-24.
- Hackett, R. I. (1994) "Women in African Religions" in Sharma, A. (ed.) Religion and Women. U.S.A.: State University of New York Press, pp. 61-92.
- Hagan, G. P. (1983) "Marriage, Divorce and Polygyny in Winneba", in Oppong, C. (ed.) Female and Male in West Africa. London: Allen and Unwin, pp. 192-203.
- Hall, E. M. (1992) "Double Exposure: The Combined Impact of the Home and Work Environments on Psychosomatic Strain in Swedish Women and Men", International Journal of Health Services, Volume 22, Number 2, Pp. 239-260.
- Harding, S. (ed.) (1987) Feminism and Methodology: Social Science Issues. Bloomington, Indiana: University of Indiana Press.
- Harstock, N. C. M. (1987) "The Feminist Standpoint: Developing the Ground For a Specifically Feminist Historical Materialism", in Harding, S. (ed.) Feminism and

- Methodology: Social Science Issues. Bloomington, Indiana: Indiana University Press, pp. 157-180.
- Harvey, K. (1991) "Sociological Methods of Research", in Tepperman, L. and Richardson, J. R. The Social World. Toronto: McGraw - Hill Ryerson Limited, pp. 34-66.
- Harvey, A. S., Marshall, K. and Frederick, J. A. (1991) Where Does Time Go?: Statistics Canada. Housing, Family and Social Statistics Division. General Social Survey Analysis Series. Ottawa: Canadian Cataloguing in Publishing Data.
- Hatem, M. F. (1994) "Privatization and the Demise of State Feminism in Egypt", in Sparr, P. (ed.) Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment. London: Zed Books Limited, pp. 40-60.
- Heise, L.L., Raikes, A., Watts, C.H. and Zwi, A.B., et al. (1994) "Violence Against Women: A Neglected Public Health Issue in Less Developed Countries", Social Science and Medicine, Volume 39, Number 9, pp. 1165-1179.
- Heise, L. (1993) "Violence Against Women: The Missing Agenda", in Koblinsky, M., Timyan, J. and Gay, J. (eds.) The Health of Women: A Global Perspective. Boulder, San Francisco: Westview Press.
- Hood, R. et al. (1992) Gender and Adjustment. (Prepared for: Office of Women and Development Bureau for Research and Development U.S. Agency for International Development Washington, DC.)

- Howie, I. (1994) "Forward", in Ardayfio-Schandorf, E. (ed.) Family and Development in Ghana. Ghana: Ghana Universities Press.
- Jacobs, S. M. and Howard, T. (1987) "Women in Zimbabwe: Stated Policy and State Action", in Afshar, H. Women, State and Ideology: Studies from Africa and Asia. USA: State University of New York Press, pp. 28-47.
- Jacobson, J. L. (1993) "Women's Health: The Price of Poverty" in Koblinsky, M., Timyan, J. and Gay, J. (eds.) The Health of Women: A Global Perspective. U.S.A: Westview Press, pp. 3-32.
- Jayaweera, S. (1994) "Structural Adjustment Policies, Industrial Development and Women in Sri Lanka", in Sparr, P. (ed.) Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment. London: Zed Books, pp. 96-115.
- Jiggins, J. (1989) "How Poor Women Earn Income in Sub-Saharan Africa and What Works Against Them", World Development, Volume 17, Number 7, pp. 953-963.
- Kabeer, N. (1991) Gender, Production and Wellbeing: Rethinking the Household Economy. Discussion Paper 288, Brighton: Institute of Development Studies, University of Sussex.
- Kabeer, N. (1992) "Feminist Perspectives in Development: A Critical Review", in H. Hilary, et al., (eds.) Working Out: New Directions For Women's Studies. London: Falmer, pp. 101-112.

- Kalu, W. (1990b) "Bereavement and Stress in Career Women", in Rothblum and Cole (eds.) Women's Mental Health in Africa. New York: The Haworth Press, pp. 75-88.
- Kanji, N., Kanji, N. and Manji, F. (1993) "From Development to Sustained Crisis: Structural Adjustment, Equity and Health", Social Science and Medicine, Volume 33, Number 9, pp. 985-993.
- Khan, Q. (1991) "The Health of Domestic Workers in South Africa", in Turshen, M. (ed.) Women and Health in Africa. Treton, New Jersey: Africa World Press, pp. 79-88.
- Klienman, S. (1991) "Field-Workers' Feelings: What We Feel, Who We Are, How We Analyze", in Shaffir, B. and Stebbins, R.A. (eds.), Experiencing Fieldwork: An Inside View of Qualitative Research. United States of America: SAGE Publications, pp. 173-184.
- Kimbal, L.A., and Craig, S. (1988) "Women and Stress in Brunei", in Whelehan, P. et. al., (eds.) Women and Health: Cross-Cultural Perspectives. Massachusetts: Bergin and Garvey Publishing Incorporated, pp. 170-182.
- Kisseka, M. N. (1990) "Gender and Mental Health in Africa", in Rothblum, E. D. and Cole, E. (eds.) Women's Mental Health in Africa. U.S.A.: The Haworth Press Incorporated, pp. 1-13.
- Kishwar, M. (1984) "Introduction", in Kishwar, M. and Vanita, R. (eds.) In Search of Answers: Indian Women's Voices From Manushi. London: Zed Press.

- Klufio, C. A. (1974) "Maternal Health and Abortion in Ghana: A Case for Family Planning", UNIVERSITAS, (An Inter-Faculty Journal, University of Ghana), Volume 4, Number 1, pp. 167-184.
- Kojo, S. (1989) "Problems of the Health Care Delivery System", in Hansen, E. and Ninsen, K.A. (eds.) The State, Development and Policy in Ghana. London: Codesria Book Series.
- LaCroix, A. Z. and Haynes, S. G. (1987) "Gender Differences in the Health Effects of Workplace Roles", in Barnett, R.C. and Biener, L. and Baruch, G. K. (eds.) Gender and Stress. New York: Free Press.
- Lado, C. (1992) "Female Labour Force Participation in Agricultural Production and The Implications for Nutrition and Health in Rural Africa", Social Science and Medicine, Volume 37, Number 7, pp. 789-807.
- Lamphey, J. J. (1977) "Patterns of Psychiatric Consultations at The Accra Psychiatric Hospital", Africa Journal of Psychiatry, Volume 3, pp. 123-127.
- Lennon, C. M. and Rosenfield, S. (1992) "Women and Mental Health: The Interaction of Job and Family Conditions", Journal of Health and Social Behaviour, Volume 33, pp. 316-327.
- Lowe, G. S. (1989) Women, Paid/Unpaid Work, and Stress: New Directions For Research. Prepared for Canadian Advisory Council on The Status of Women, Toronto.

- Lowenson, R. (1991) "Harvests of Disease: Women at Work on Zimbabwean Plantations" in Turshen, M. (ed.) Women and Health in Africa. Treton, New Jersey: Africa World Press, pp. 35-50.
- Lubanga N. (1991) "Nursing in South Africa: Black Women Workers Organize", pp. 51-78 in Turshen, M. (ed.) Women and Health in Africa. Treton, New Jersey: Africa World Press.
- Lugones, M. C. and Spelman, E. V. (1983) "Have We Got a Theory for You! Feminist Theory, Cultural Imperialism and the Demand for 'The Woman's Voice'", in Women's Studies International Forum, Volume 6, Number 6, pp. 573-581.
- Luxton, M. (1980) More Than a Labour of Love. Toronto: The Women's Press.
- MacCormack, C. P. (1989) "Technology and Women's Health in Developing Countries", International Journal of Health Services, Volume 19, Number 4, pp. 681-692.
- Macintyre, S. (1986) "The Patterning of Health by Social Position", Social Science and Medicine, Volume 23, Number 23, pp. 393-415.
- Mackintosh, M. (1979) "Domestic Labour and the Household", in Burman, S. (ed.) Fit Work for Women. London: Crown Helm, pp. 173-191.
- Manuh, T. (1994) "Ghana: Women in the Public and Informal Sectors Under the Economic Recovery Programme", in Sparr, P. (ed.) Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment. London and New Jersey: Zed Books Limited, pp. 61-72.

- Marshall, A. (1994) "Sensous Sapphires: A Study of the Social Construction of Black Female Sexuality", in Maynard, M. and Purvis, J. (ed.) Researching Women's Lives from a Feminist Perspective. London: Taylor and Francis Limited, pp. 106-124.
- Mebrahtu, S. (1991) "Women, Work and Nutrition in Nigeria", in Women and Health in Africa. Turshen, M. (ed.), Trenton, New Jersey: Africa World Press.
- Miles (1988) Women and Mental Illness. Brighton: Houghton Mufflin.
- Miles, A. (1991) Women, Health and Medicine. Milton Keynes: Open University Press.
- Ministry of Health of Ghana. (1990) "Family Planning and the PHC by TBAs", Final Report, Operations Research Project, Between MOH and Columbia University, U.S.A.
- Mishler, E. G. (1989) "Critical Perspectives on the Biomedical Model." in Brown, P. (ed.) Perspectives in Medical Sociology. Belmont, California: Wadsworth Publishing Company, pp. 153-165.
- Momsen, J. H. (1991) Women and Development in the Third World. London and New York: Routledge.
- Momsen, J. H. and Townsend, J. (eds.) (1987) Geography and Gender in the Third World. London: Hutchinson.
- Morgan, M., Calnan, M. and Manning, N. (1988) Sociological Approaches to Health and Medicine. London and New York: Routledge.
- Mwaka, V. M. (1993) "Agricultural Production and Women's Time Budgets in Uganda", in Momsen, J. H. and Kinnaird, V. (eds.) Different Places, Different Voices: Gender

- and Development in Africa, Asia and Latin America. London and New York: Routledge, pp. 46-51.
- Nairne, K. and Smith, G. (1984) Dealing With Depression. London: Women's Press.
- Nathenson, C. (1989) "Sex, Illness, and Medical Care: A Review of Data, Theory, and Method", in Brown, P. (ed.) Perspectives in Medical Sociology. Belmont, California: Wadsworth Publishing Company, pp. 46-71.
- Navarro, V. (1981) Imperialism, Health and Medicine: Policy, Politics, Health and Medicine Series. New York: Baywood Publishing Company Incorporated.
- Navarro, V. (1986) Crisis, Health and Medicine: A Social Critique. New York: Tavistock Publishers.
- Navarro, V. (1984) "A Critique of the Ideological and Political Position of the Brandt Report and the Alma Ata Declaration", International Journal of Health Services, Volume 14, Number 2, pp. 159-172.
- Nikoi, G. (1990) "Women's Access to Credit in Africa", in Women and Credit: Research Series, United Nations International Research and Training Institute for the Advancement of Women. Santo Domingo, pp. 142-161.
- Norton, A. (1988) "Ghana Social Profile", London: ODA.
- Novek, J. Yassi, A. and Spiegel, J. (1990) "Mechanization, The Labour Process, and Injury Risks in The Canadian Meat Packing Industry", International Journal of Health Services, Volume 20, Number 2, pp. 281-296.

- Nukunya, G. K. (1992) Tradition and Change in Ghana: An Introduction to Sociology. Ghana: Ghana Universities Press.
- Nukunya, G. K., and Twumasi, P. A. (1978) "Traditional Attitudes Towards Health, Disease and Family Planning: Some Policy and Planning Implications", Paper Presented at The Seminar on Integration of Theory and Policy in Population Studies Held at The University of Ghana, Legon, January 2-5.
- Oakley, A. (1981) "Interviewing Women: A Contradiction in Terms", in Roberts, H. (ed.) Doing Feminist Research. London: Routledge and Kegan, pp. 30-61.
- Oakley, A. (1984) The Captured Womb: A History of the Medical Care of Pregnant Women. Blackwell: Oxford.
- Ofei-Aboagye, R. O. (1994) "Altering the Strands of the Fabric: A Preliminary Look at Domestic Violence in Ghana", in Signs: Journal of Women in Culture and Society, Volume 19, Number 4.
- Oheneba-Sakyi, Y. (1990) "Socio-Economic and Cultural Differentials in Contraceptive Usage Among Ghanaian Women", International Journal of Sociology of The Family, Volume 20, Number 2, pp. 139-161.
- Ofori-Atta, A. M. L. and Linden, W. (1995) "The Effect of Social Change on Causal Beliefs of Mental Disorders and Treatment Preferences in Ghana", In Social Science and Medicine, Volume 40, Number 9, pp. 1231-1242.

- Okali, C. (1983) "Kinship and Cocoa Farming in Ghana", in Oppong, C. (ed.) Female and Male in West Africa. London: Allen and Unwin, pp. 169-178.
- Okojie, C. E. E. (1994) "Gender Inequalities of Health in the Third World", Social Science and Medicine, Volume 39, Number 9, pp. 1237-1247.
- Opoku, K. A. (1978) West African Traditional Religion. Singapore: FEP International Private Limited.
- Oppong, C. (ed.) (1974) "Domestic Rights and Duties in Southern Ghana", Legon Family Research Papers, Number 1, Accra, Legon: Institute of African Studies.
- Oppong, C., Okali, C. and Houghton, B. (1975) "Woman Power: Retrograde Steps in Ghana", African Studies Review, Volume XVIII, Number 3.
- Orley, J. (1972) "A Prospective Study of 372 Consecutive Admissions to Butabika Hospital, Kampala", East African Medical Journal, Volume 9, pp. 16-26.
- Orubuloye, I. O., Caldwell, J. C. and Caldwell, P. (1993) "African Women's Control Over Their Sexuality in An Area of AIDS." Social Science and Medicine, Volume 37, Number 7, pp. 859-872.
- Otsyula, W. and Rees, P. H. (1972) "The Occurrence and Recognition of Minor Psychiatric Illnesses Among Out-Patients at Kenyatta National Hospital, Nairobi", East African Medical Journal, Volume 49, pp. 825-829.
- Owusu, D. R. (1994) "The Woman After Menopause: A Case Study of Kpando Women", A Dissertation Presented to the Department of Sociology, University of Ghana in

partial Fulfilment of the Requirements For the Award of Bachelor of Arts (Honours)
Degree (Unpublished).

- Paltiel, F. L. (1993) "Women's Mental Health: A Global Perspective", in Koblinsky, M. Timyan, J. and Gay, J. (eds.) The Health of Women: A Global Perspective. U.S.A: Westview Press, pp. 197-216.
- Paolisso, M. and Leslie, J. (1995) "Meeting the Changing Health Needs of Women in Developing Countries", in Social Science and Medicine, Volume 40, Number 1, pp. 55-65.
- Parpart, J. and Staudt, K. A. (eds.) (1989) Women and the State in Africa. Boulder Colorado: L. Reinner Publishers.
- Patai, D. (1991) "U.S. Academics and Third World Women: Is Ethical Research Possible?" in Gluck, S. and Patai, D. (eds.) Women's Words: The Feminist Practice of Oral History. Bloomington: Indiana University Press, pp. 137-153
- Payne, S. (1991) Women, Health Poverty. London: Harvester Wheatsheaf.
- Pearlin L. I., and Anashensel, C. S. (1989) "Stress, Coping, and Social Supports" in Brown, P.(ed.) Perspectives in Medical Sociology. Belmont, California: Wadsworth Publishing Company, pp. 95-102.
- Penfold, P. S. and Walker, G. A. (1983) Women and The Psychiatric Paradox. Montreal: Eden Press Incorporated.

- Phoenix, A. (1994) "Practising Feminist Research: The Intersection of Gender and 'Race' in the Research Process", in Maynard, M. and Purvis, J. (ed.) Researching Women's Lives from a Feminist Perspective. London: Taylor and Francis Limited, pp. 49-71.
- Population Census of Ghana (1984) Volta Region.
- Popay, J. and Jones, G. (1990) "Patterns of Health and Illness Amongst Lone Parents", Journal of Social Policy, Volume 19, Number 4, pp. 499-534.
- Raikes, A. (1989) "Women's Health in East Africa", Social Science and Medicine, Volume 28, Number 5, pp. 447-459.
- Rathgeber, E. and Vlassoff, C. (1993) "Gender and Tropical Disease: A New Research Focus", Social Science and Medicine, Volume 37, Number 4, pp. 513-520.
- Renaud, M. (1975) "On The Structural Constraints to State Intervention in Health", International Journal of Health Services, Volume 5, Number 4, pp. 559-572.
- Reed, W. L. (1990) "Racism and Health: The Case of Black Infant Mortality", in Conrad, P. and Kern, R. (eds.) The Sociology of Health and Illness. (Third Edition) New York: St. Martin's Press, pp. 34-45.
- Roberts, P. A. (1987) "The State and the Regulation of Marriage: Sefwi Wiawso (Ghana) 1900-40" in Afshar, H. (ed.) Women, State, and Ideology: Studies from Africa and Asia. USA: State University of New York Press, pp. 48-69.
- Robertson, C. (1983) "The Death of Makola and Other Tragedies", Canadian Journal of African Studies, Volume 17, Number 3, pp. 469-495.

- Robertson, C. (1984) Sharing the Same Bowl: A Socioeconomic History of Women and Class in Accra, Ghana. Bloomington, Indiana: Indiana University Press.
- Rodda, A. (1991) Women and the Environment. London: Zed Press.
- Ronkoli, M. I. (1985) "Women and Small-Scale Farming in Ghana", Women in International Development Working Paper Series. Michigan State University.
- Rutenberg, B. A. K. (1991) "Coitus and Contraception: The Utility of Data on Sexual Intercourse For Family Planning Programmes", Studies in Family Planning, Volume 22, Number 3, pp. 162-176.
- Sai, F. T. (1986) "Family Planning and Maternal Health Care: A Common Goal", World Health Forum, Volume 7, pp. 315-324.
- Sanjek, R. (1983) "Female and Male Domestic Cycles in Urban Africa: the Adabraka Case", in Oppong, C., (ed.) Female and Male in West Africa. London: Allen and Unwin, pp. 331-343.
- Santow, G. (1995) "Social Roles and Physical Health: The Case of Female Disadvantage in Poor Countries", Social Science and Medicine, Volume 40, Number 2, pp. 147-161.
- Sen, G. Grown, C. (1987) Development, Crises, and Alternative Visions: Third World Women's Perspectives. New York: Monthly Review Press.
- Shaffir, B. (1991) "Managing a Convincing Self-Presentation: Some personal Reflections on Entering the Field", in Shaffir, B. and Stebbins, R.A. (eds.) Experiencing Fieldwork:

An Inside View of Qualitative Research. United States of America: SAGE Publications, pp. 62-72.

Shaffir, B. and Stebbins, R. A. (1991) Experiencing Fieldwork: An Inside View of Qualitative Research. United States of America: SAGE Publications.

Shaw-Taylor, R. (1981) "Signs of Mental Stress in Ghana", in Blair, P. W. (ed.) Health Needs of the World's Poor Women. Washington D.C. Equity Policy Centre. Based on the Proceedings of the International Symposium on Women and their Health, Sponsored by Equity Policy Centre and Held in June 8-11, 1980, Port Deposit, Maryland, pp. 18-21.

Smith, B. E. (1989) "Black Lung: The Social Production of Disease", in Brown, P. (ed.) Perspectives in Medical Sociology. Belmont, California: Wadsworth Publishing Company, pp. 122-141.

Smith, D. (1987) The Everyday World as Problematic: A Feminist Sociology. Toronto: University of Toronto Press.

Smyke, P. (ed.) (1991) Women and Health. London: Zed Books Limited.

Sparr, P. (1994) "What is Structural Adjustment?" in Sparr, P. Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment. London and New Jersey: Zed Books Limited, pp. 1-12.

- Stanley, L. (1990) "Feminist Praxis and the Academic Mode of Production: An Editorial Introduction", in Stanley, L. (ed.) Feminist Praxis: Research, Theory and Epistemology in Feminist Sociology. London and New York: Routledge, pp. 3-19.
- Stebbins, R. A. (1991) "Do We Ever Leave the Field?" Notes on Secondary Fieldwork Involvements", in Shaffir, W. B. and Stebbins, R. A. (eds.) Experiencing Fieldwork: An Inside View of Qualitative Research. California: SAGE Publications, pp. 248-255.
- Stinson, W. (1986) Women and Health. Washington, D.C.: Prepared For The Aga Khan Foundation and UNICEF, U.S.A: Automated Graphic Systems.
- Sundari, T. K. (1993) "The Untold Story: How the Health Care System in Developing Countries Contribute to Maternal Mortality", International Journal of Social Services, Volume 22, Number 3, pp. 523-528.
- Swift C. R. and Asuni, T. (1975) Mental Health and Disease in Africa. London: Churchill Livingston.
- Taylor, S. J. (1991) "Leaving the Field: Research, Relationships, and Responsibilities", in Shaffir, W. B. and Stebbins, R. A. (eds.) Experiencing Fieldwork: An Inside View of Qualitative Research. California: SAGE Publications, pp. 232-238.
- The World Bank Development Report, (1985) New York: Oxford University Press.
- Tepperman, L. and Richardson, J. R. (1991) The Social World. (Second Edition) Toronto: McGraw-Hill Ryerson Limited.

- Trenchard, E. (1987) "Rural Women's Work in Sub-Saharan Africa and the Implications for Nutrition", in Momsen, J. H. and Townsend, J. G. (eds.) Geography of Gender in the Third World. London: Butler and Tanner Limited, pp. 153-172.
- Turshen, M. (1991) Women and Health in Africa. Trenton, New Jersey: Africa World.
- Turshen, M. (1984) The Political Ecology of Disease in Tanzania. New Jersey: Rutgers University Press.
- Twumasi, P. A. (1981) "Colonialism and International Health: A Study in Social Change in Ghana", Social Science and Medicine, Volume 15B, pp. 147-151.
- Twumasi, P.A. (1977) "Health Problems of Women: A Sociological Comment", Paper Presented at The Eleventh Annual Sociological Conference, Cape Coast, University of Cape Coast, March 2nd April.
- Twumasi, P. A. (1979) "A History of the Ghanaian Pluralistic Medical Systems", Social Science and medicine, Volume 13b, pp. 349-356.
- Twumasi, P. A. (1975) Medical Systems in Ghana: A Study in Medical Sociology. Accra: Ghana Publishing.
- United Nations (1991) The World's Women 1970-1990: Trends and Statistics. New York.
- United Nations (1989) World Survey on the Role of Women in Development. New York.
- United Nations (1990) Human Development Report. New York: Oxford University Press.
- UNICEF (1996) The State of the World's Children. New York: Oxford University Press.
- UNICEF (1995) The State of the World's Children. New York: Oxford University Press.

- UNICEF (1993) The State of the World's Children. New York: Oxford University Press.
- UNICEF (1991) The State of the World's Children. New York: Oxford University Press.
- Vebrugge, L. M. (1987) "Gender and Health: An Update on Hypotheses and Evidence", in Schwartz, H. D., Dominant Issues in Medical Sociology. New York: Random House, pp. 661-689.
- Vercrujisse, E. (1983) "Fishmongers, Big Dealers and Fishermen: Co-operation and Conflict Between the Sexes in Ghanaian Canoe Fishing", in Opong, C. (ed.) Female and Male in West Africa, London: Allen and Unwin, pp. 179-191.
- Waitzkin, H. (1989) "Social Structures of medical Oppression: A Marxist View", in Brown, P. (ed.) Perspectives in Medical Sociology. Belmont California: Wadsworth Publishing Company, pp. 166-178.
- Waitzkin, H. (1983) The Second Sickness: Contradictions of Capitalist Health Care. New York: Free Press.
- Waldron, I. (1990) "What Do We Know about Causes of Sex Differences in Mortality," in Conrad P. and Kern, R. (eds.) The Sociology of Health and Illness: Critical Perspectives. (Third Edition) New York: St. Martin's Press, pp. 45-57.
- Walmsley, J. (1993) "Explaining" in Shakespeare, P., Atkinson, D. and French, S. (eds.) Reflecting on Research Practice: Issues in Health and Social Welfare. Buckingham: Open University Press, pp. 36-46

- Walters, V., Lenton, R. and McKeary, M. (1995) Women's Health in the Context of Women's Lives: A Report Submitted to the Health Promotion Directorate, Health Canada. Canada.
- Walters, V. (1991) "Beyond Medical and Academic Agendas: Lay Perspectives and Priorities", Atlantis, Volume 17, Number 1, pp. 28-35.
- Walters, V. (1993) "Stress, Anxiety and Depression: Women's Accounts of their Health Problems", Social Science and Medicine, Volume 36, Number 4, pp. 393-402.
- Warren, C. A. B. (1988) Gender Issues in Field Research: Qualitative Research Methods. Series 9, U.S.A: Sage Publications Incorporated.
- Wertz, R. W. and Wertz, D. C. (1990) "Notes on the Decline and the Rise of Medical Obstetricians", in Conrad, P. and Kern, R. (eds.) The Sociology of Health and Illness: Critical Perspectives. (Third Edition) New York: St. Martin's Press, pp. 148-161.
- Whitehead, A. (1994) "Wives and Mothers: Female Farmers in Africa", in Adepoju, A. and Opong, C. (eds.) Gender, Work and Population in Sub-Saharan Africa. London: Heinemann, pp. 35-54.
- Woodhandler et. al. (1989) "Medical Care and Mortality: A Racial Differences in Preventable Deaths", in Brown, P. (ed.) Perspectives in Medical Sociology. (Second Edition). California: Wadsworth Publishing Company, pp. 71-82.
- World Health Forum (1986) "Forum Interview: Prevention of Maternal Mortality", Volume 7, pp. 50-55.

World Health Organization (1984) Biomass Fuel Combustion and Health. Geneva: World Health Organization.

WHO Chronicle (1986) Volume 40, Number 5, pp. 175-183.

Young, K. (1993) Planning Development with Women: Making a World of Difference. London: Macmillan.

INTERVIEW GUIDE

Interview Number: _____

Good morning/Afternoon/evening. How are the children and everybody else? Thank you very much for giving me the opportunity to meet with you. I hope not to take too much of your time. I am Joyce Avotri. I am from Sovie. I attended secondary school here in Kpando and went on to the university ('Legon skul korkor'). I am currently doing more studies about women's health, overseas (at 'Abrotsi'). The reason I have come back to visit Kpando is that I am now trying to learn more about women's worries ('efudede', 'dzitsitsi', 'kuhi', 'nuhaha' etc.) in general, their worries about their health and what they think causes health problems. We may be conversing for a while and we will cover a wide range of issues concerning things that worry us as women. All the things that we are going to talk about today are very important to me since it will help me know and understand the situation of women in Ghana and help me in my studies. I regard your answers as confidential and because of that I will not write down your name. If you prefer not to answer some of the questions I am about to ask please feel free to tell me. Would you mind if I taped our conversation? I will teach you how the tape recorder works.

1. Who lives with you in your household?
[husband/partner (ie. marital status), children and their ages, other relatives, eg. mother/father, aunt/uncles, in-laws etc.]
Where are they? How frequently do you hear from/see them?
2. Do you have a job?
[Probe for type of job, the nature/content of the job, number of hours eg. per day or week on the job, how long she has been doing that job, and her views concerning the job, does she like it?]
When was the last time you had a job? (if no occupation)
Do you have any other means of subsistence? (eg. subsistence farming etc.)
3. What about those who live with you, do they have jobs?
[Probe for job of husband/partner, children, whether they go to school or work, and other members of the household.]
4. How do you go about your day?
[Probe for the work activities undertaken during the day, conditions in the household/community ie. social facilities in the house eg. water, electricity etc.]

5. With your responsibilities and work activities, can you tell me what it is like being a woman?
[Probe for views on women's lives, and perceptions of women who find themselves in different situations, eg. older and single women, barren/infertile, divorced or widowed women etc. May also include narration of their life histories etc.]
6. What do you worry about of late?
[If health problems are mentioned, follow the flow of the conversation and probe for further information on worries about health.]
7. What health problems do you worry about?
For each of the health problems mentioned:
Why does that worry you?
Do you know of any one who has had any of these health problems?
8. What health problems have you actually experienced?
When was the last time you felt you were not feeling fine? What was wrong?
How do you experience it? How long have you been like this? What impact has it had on your life? What do you think causes/caused it? Why do you think that? How do you cope with it? Anything else? Any other health problems?
9. Do you think you are a healthy person? Why is that?
10. What about women in Kpando, what health problems do they worry about?
Why do you say that? Of the health problems you have mentioned, which ones do women talk about most? Do you know of any women who have suffered from any of these?
11. What about mental health problems?
How do you understand mental health (taagbordor)? What kinds of problems do you think of as mental health problems? Are these also problems that women experience?
12. Have you experienced any of these mental health problems?
What are/were they? How do/did you feel? Have you discussed it with any one? How do/did you cope with it? Who do/did you consult? Are you happy with the treatment?
13. In your view, how do you think we can improve the lives and health of women?
Is there anything else you would like me to know about the health of women?

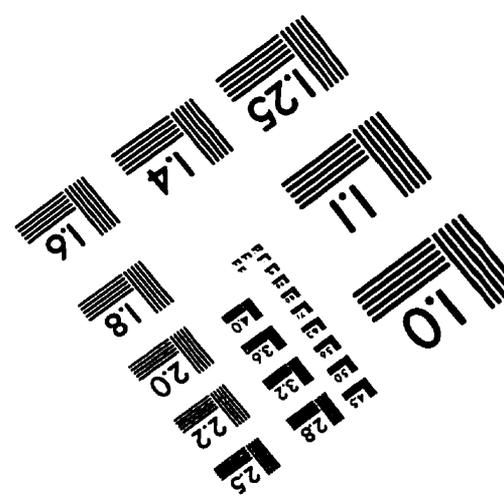
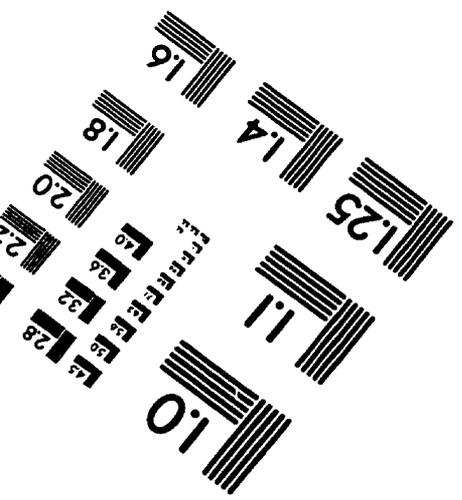
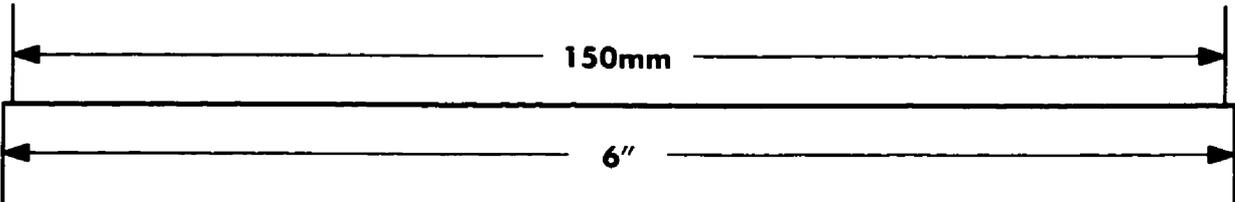
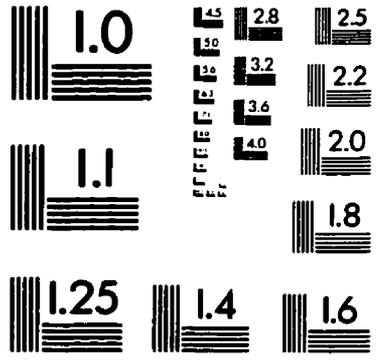
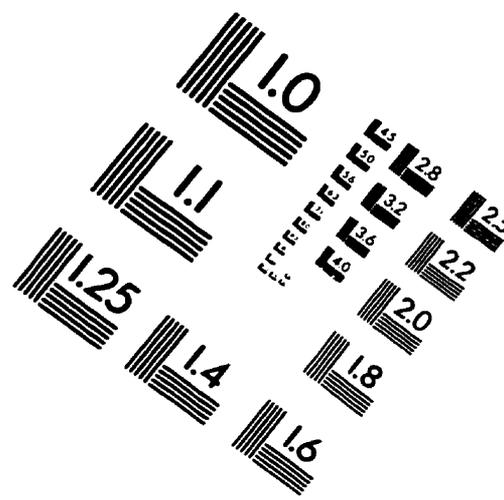
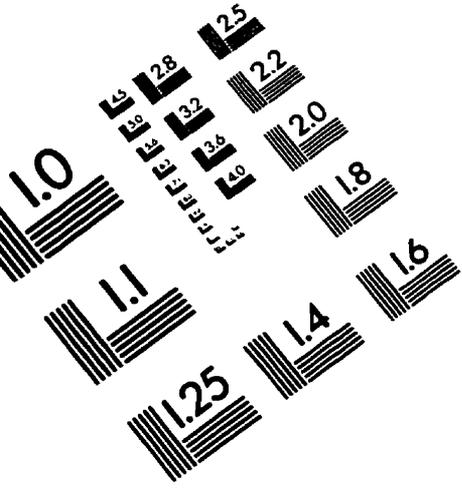
For me to remember the range of women I interviewed, would you please tell me:

14. When were you born/how old are you?
15. What is your religious denomination?

16. Have you ever been to school?
What is your qualification?
17. What are your sources of income?
Can you estimate your household income?
I don't need the exact figure, can you tell me the range.

THANK YOU VERY MUCH

IMAGE EVALUATION TEST TARGET (QA-3)



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