'We Women Worry a Lot About Our Husbands': Ghanaian women talking about their health and their relationships with men

Joyce Yaa Avotri & Vivienne Walters

Published online: 03 Aug 2010.

To cite this article: Joyce Yaa Avotri & Vivienne Walters (2001) 'We Women Worry a Lot About Our Husbands': Ghanaian women talking about their health and their relationships with men, Journal of Gender Studies, 10:2, 197-211, DOI: 10.1080/09589230120053319

To link to this article: http://dx.doi.org/10.1080/09589230120053319

PLEASE SCROLL DOWN FOR ARTICLE
‘We Women Worry a Lot About Our Husbands’: Ghanaian women talking about their health and their relationships with men

JOYCE YAA AVOTRI & VIVIENNE WALTERS

ABSTRACT Discussions of the health of women in the developing world have typically been shaped by the concerns of policy makers, health care professionals and other experts. They have focused on reproductive health and, above all, women have been defined in terms of their childbearing role. Yet when women themselves are given a voice, a different set of issues emerges. The research reported here aimed to explore women’s own concerns about their health and how they understand their health problems. The study was conducted in the Volta region of Ghana and it included interviews with 75 women of varying background. Almost three-quarters of the women reported ‘thinking too much’ and many also said that they had problems sleeping, suffered frequent headaches and often felt unhappy or sad. They explain these psycho-social health problems in terms of their social and material circumstances and one of the main themes emphasised was their relationships with men. Relying on women’s accounts, we trace the ways in which they conceptualised their health, seeing it as shaped by their lack of control over the conditions of their lives; gender relations define their responsibilities while at the same time withholding the control and resources they require in order to achieve a measure of economic independence and predictability.

Insofar as attention has been directed to the health of women in the developing world, it has generally focused on generational reproduction. Avotri (1997), Lewis and Kieffer (1994), MacCormack (1989) and Rathberger and Vlassoff (1993) are among a handful of writers who have drawn attention to the limits of this emphasis, showing how it creates a very partial picture of the dimensions of women’s lives. Above all, women have been defined in terms of their childbearing role. At the same time, discussions of women’s health have been shaped by the concerns of policy makers, health care professionals and other experts. Seldom have women themselves been consulted about their main health concerns (Avotri, 1997; Walters, 1991), yet when they are asked about their health a different picture often emerges (Walters et al., 1999). This paper reports on a study which aimed to document the health concerns of a sample of Ghanaian women. We were
interested in whether women do indeed emphasise reproductive health issues and also in how they understand the health problems they experience.

Reproductive health was not a strong theme. Instead, women emphasised psychosocial health problems. Worrying and ‘thinking too much’ were the problems most often reported by the women; almost three-quarters of the sample described such problems (Avotri, 1997; Avotri and Walters, 1999a). They also found it difficult to sleep and had frequent headaches. A few reported problems with high blood pressure. Several of them said that because of their worries they would sometimes behave eccentrically—talking to themselves or throwing their hands into the air as they walked along the road. In summing up the lot of women, it was said that ‘a woman’s heart is never free’. One quotation serves to illustrate the types of health problems women mentioned. This woman had problems in her marriage and she was worried about her children:

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)

The interviews document such problems—problems that are often neglected in discussions of women’s health—and they also contribute to our understanding of women’s concepts of health and the causes of ill-health. Women’s accounts generally did not reflect the biomedical models that are more common in the developed world, though the problems they mentioned would typically be regarded as symptoms of depression in the West and treated with psychotropic medication—inomnia, loss of weight, worrying, crying. In this sample, while women did often rely on medication (though few said they took psychotropic drugs) they explained their problems in social terms and wanted better education, jobs for women in the formal sector and easier access to credit (Avotri & Walters, 1999b). Women did not dwell on their own culpability. The cultural–behavioural explanations that have been emphasised in health promotion campaigns in the West stress individual responsibility and can easily lead to women blaming themselves for smoking, not getting enough exercise and so on (Nettleton, 1996). There was no evidence in these interviews of women worrying about such issues—the problems were of getting enough to eat (not too much) and of having to walk long distances to collect fuel wood and water (rather than trying to compensate for a sedentary life style with exercise). Neither did women dwell on issues such as family size, nutrition and sanitation. These have often been stressed in health education programmes in the developing world and they, too, emphasise women’s responsibility for their own health and that of their families. Women did not berate themselves for not taking care of their health; they viewed health in social rather than individualistic terms.

Because they understood their health problems in relation to the circumstances of their lives, there was little sense that ‘health’ was something separate from day-to-day living. Indeed, the idea that health is something distinct from everyday life has its roots in biomedicine. For these Ghanaian women, ‘health’ appeared to be inseparable from the material and social conditions of their lives. There is a similar emphasis on the social
roots of health problems in women’s accounts in the developed world (Walters et al., 1999), but the balance is different in the interviews with Ghanaian women, with less attention to biomedical and behavioural themes.

Women understood their health in terms of their roles in production and social reproduction. They described the work they do and the different ways they seek to earn a living to support their families. We have discussed elsewhere the health implications of women’s roles as workers (Avotri & Walters, 1999a) and drawn parallels with women’s concepts of health in the West (Walters et al., 1999). In this paper, we develop another strong theme in the interviews—the ways in which women explain their health problems in terms of gender relations. We trace ways in which women feel their health is shaped by gender and, especially, by their relationships with men. In so doing, we draw on Ghanaian women’s own accounts of their problems and the insecurity and lack of control they experience in their day-to-day lives. In the following sections we show how women felt that such aspects of gender relations affect their lives and their health. Many of them said that their relationships with men influenced their well-being; they were central yet problematic. They argued that their relationships made them ‘worry too much’ and ‘think too much’ and they often felt unhappy or depressed.

Such problems can be understood in terms of women’s lack of control over the conditions of their lives. The lack of power associated with traditional gender relations provides a context for interpreting the experiences of which women spoke. Women are faced with culturally based ideals of what it is to be a woman, wife or mother, yet they encounter obstacles in seeking to meet these expectations (Davis & Low, 1989; Dunk, 1989; Rozemberg & Manderson, 1998; Walters, 1993; Walters & Charles, 1997). Women are expected to provide for their families, yet they face economic uncertainty and discrimination in their access to jobs, land and credit. The importance of marriage, alongside women’s social and economic dependence on men, prompts a sense of insecurity and in this study women explained that they worried that their husbands would desert them or have affairs. This also meant that they often had to tolerate physical and verbal abuse from their husbands. Doyal (1995, p. 45) has written of the ‘contradictory and demanding reality of so many women’s daily lives’ which provokes problems that find expression in different forms depending on the cultural context. Idioms of distress which assume the form of nerves, anxiety and depression in some cultures, appear to find expression as ‘worrying too much’ or ‘thinking too much’ in Ghana and these, in turn, are accompanied by other low-level psycho-social problems.

We discuss these themes in the sections below. First, in order to provide a context for women’s accounts, we describe the setting of the research and the sample.

The Study

The research was conducted between November 1994 and March 1995 in a town in the Volta region of Ghana, West Africa. It has a population of almost 16,000 and is one of the district headquarters in the region. The town has electricity, a post office, banks, a hospital, a health centre, a market and secondary schools. However, the roads linking the town to outlying areas are poor and in the wet season are sometimes impassable by vehicles. Lack of clean drinking water is a major problem and women and children may walk a long way, standing in line for several hours to buy water, or else they will rely on wells, rivers and streams for their water, though these are unsafe. Many houses do not have toilets and people often walk long distances to use public latrines which are few and often in poor condition.
TABLE 1. The sample (N= 75)

<table>
<thead>
<tr>
<th>Age</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–39 years</td>
<td>33</td>
<td>44</td>
</tr>
<tr>
<td>40–59 years</td>
<td>33</td>
<td>44</td>
</tr>
<tr>
<td>60–80 years</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Marital status

<table>
<thead>
<tr>
<th>Marital status</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married/cohabiting</td>
<td>38</td>
<td>51</td>
</tr>
<tr>
<td>Absentee husbands</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Widowed</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Single</td>
<td>13</td>
<td>17</td>
</tr>
</tbody>
</table>

Primary occupation

<table>
<thead>
<tr>
<th>Primary occupation</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Clerical, sales and service</td>
<td>18</td>
<td>24</td>
</tr>
<tr>
<td>Trader</td>
<td>24</td>
<td>32</td>
</tr>
<tr>
<td>Farmer</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Labourer</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>No longer working because of ill health or old age</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Homemaker</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The research included interviews with 75 women and the sample was developed through a ‘snowball’ technique. The composition of the sample is shown in Table 1. It included a broad spectrum of women and, though it is not wholly representative of women in the area, it does include a range of experiences and is ideal for exploratory research. Almost two-thirds (63 per cent) of the sample had a male partner, though some of these had absentee husbands who had migrated to find work or who were estranged.

Most women were engaged in economic activity. Typically they were traders or farmers. Part of the produce from their farms was usually sold in the local market for cash and was thus a source of income for the women. A few of the women were teachers, secretaries, nurses, hairdressers and seamstresses and many of them also engaged in several other different income-generating activities. For example, they might combine farming, trading, office work, hairdressing, baking or sewing. In addition to the work they did to earn money, they had to attend to childcare and domestic tasks and these absorbed long hours because of the time spent in food preparation as well as fuel and water collection.

Because few studies of women’s health in the developing world have focused on women’s own concerns, we aimed to capture health problems from the point of view of women themselves. Almost all the interviews were conducted in the local language, Ewe. They were done by the first author who is fluent in Ewe and who, as a child, lived and went to school in the town. The interviews were tape recorded and translated into English as they were transcribed. Women were asked about their main health problems and they were encouraged to talk at length about their day-to-day activities and the ways these might be linked with their health. It is not easy to make direct literal translations though we have sought to convey the spirit of the conversations and sometimes included the original Ewe expressions. However, research which investigates ‘health’ almost inevitably involves separating it out as a concept. As a result it takes on a status that is not quite so distinct in the concepts of the women we interviewed. In this regard our own
cultural lens influences the analysis, but by relying on women’s own words we hope to avoid this as much as possible. The analysis of the transcripts has focused on the main problems reported by women (Avotri, 1997), how these flow from and also influence their lives, and how they cope with them (Walters et al., 1999). Women spoke about their workloads (Avotri & Walters, 1999a) and the effects of their relationships with men; these were the main themes in their accounts of their health. It is the latter which is the focus of this paper. In the following sections we show how women described the way in which household responsibilities were divided by gender, their fears about being deserted by their partners and the physical and verbal abuse suffered by some women. At the same time we show how the respondents linked these with the health problems they experienced.

The Gender Division of Labour

Marriages in West Africa represent a bond between two kin groups and the relationship between a husband and wife is not central. Neither is there a strong tradition of husband and wife sharing resources and engaging in joint decision making (Manuh, 1994; Potash, 1995). Patriarchal relations are strong and men continue to control most productive resources such as land, livestock, tools and means of transport. They also retain most of the proceeds of their work while expecting their wives to meet most of the family’s needs through food production and earnings from other income-generating activities (Koopman, 1995). In addition to men’s control of resources, the development of new technologies has done little to increase the productivity of women’s work and they also face barriers in obtaining credit. Thus, women continue to be socially and economically dependent on men even though they often provide the bulk of the household income (Ardayfio-Schandorf, 1993).

Koopman (1995, p. 16) argues that women have shown an ‘impressive physical and technological capacity to make a living for themselves and their families’, yet they face major constraints in their efforts to achieve economic independence. ‘Women’s efforts to improve their conditions take place in circumstances not of their own making’ (Schoepff, 1998, p. 103); legal and political systems that support women’s limited control of productive resources have combined with the effects of national and international markets to narrow women’s opportunities (Guyer, 1995). The financial problems that African women face, exacerbated by food shortages, the debt crisis and structural adjustment programmes (Manuh, 1994; Schoepff, 1998; Staudt, 1995) mean that they carry an increasingly heavy work load. Work at home is time consuming—food preparation, fuel wood gathering and water collection take many hours (Avotri & Walters, 1999a; Ardayfio-Schandorf, 1993)—and women also juggle several different projects and jobs to bring money into the household. Yet, despite their increasing workloads, women have seen little improvement in their economic situation.

These themes were apparent in the interviews. Many women spoke of their heavy workloads and the limited control that they had over their work and their ability to earn income. They 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 take responsibility for the children and the household. Women felt that their work load was increasing and that even though they themselves worked hard, men contributed little to household expenses and often squandered money. Yet men could make claims on resources because of their position in the household while also expecting women to bear full responsibility for child care, cooking and other domestic tasks at the same time as
earning money to maintain the household. They said that the insecurity and unpredictability that women experienced was a source of worry and ‘thinking too much’—the main psycho-social health problems they reported.

Women are expected to make a significant contribution to household expenses (Potash, 1995; Raikes, 1989) and one respondent said that in lean times some husbands expected women to supplement the money by working even harder. This meant that women, in particular, bore the brunt of broader economic problems:

Yes, because of the economy, men ... 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)

Another respondent said 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. Her expenses were far more than the money provided by her husband.

Yet even though women bear this responsibility for generating income, they do not control their own labour; men can claim their rights to women’s labour without compensation (Raikes, 1989). For example, one woman explained that she helped her husband to brew gin for sale, but her husband did not pay her or share any money with her. She said that the uncertainties created by her lack of money were a source of considerable worry; she found herself crying frequently and had a lot of headaches.

... even though I work 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)

And men have control over household resources also, despite the fact that women cannot count on them to bring sufficient money into the home. Men often expect priority in access to food, even though they might make only a small contribution to household expenses. Several women said that they would feed their husbands and children first, and that men would expect to eat before their children:

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)

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

We men suffer a lot. Hmmm, 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’. 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)

Another woman recounted an incident in which a man who had been enjoying good meals in ‘chop bars’ without his wife’s knowledge, was caught when he became very sick and nauseous one day and his wife discovered the content of the vomit!

One respondent said that her husband, a tutor in one of the local secondary schools, gave her an insufficient monthly allowance for the care of the household while he spent the rest of his pay cheque on ‘Akpeteshi’ (the local gin) and did not care whether or not there was enough money for the family of five. At the end of the month he might owe
the gin seller as much or even twice as much as he gave to his wife. 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. She felt she was doing everything she could to put food on the table, while her husband would return home drunk.

Women are typically expected to prepare food, serve their husbands and look after domestic tasks. Respondents complained about men’s unwillingness to help with household chores and childcare, despite the fact that the women were often financially responsible for the household. A trader complained that her husband never helped with household tasks when he returned from work. Instead he went to town to drink with his friends. 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. Their daughter was of age and could cook, yet he was unwilling to eat the food she cooked. This woman was thus expected to leave the market for home to make the evening meal at the time that business was 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. (Int. 40)

A similar complaint was made by another woman who was very bitter about her husband’s refusal to help with chores in the house and childcare even though she was the one who had an office job. She had asked her husband to pay for household help since he was unwilling to take any responsibility, but he had refused. She said that when she complained, he retorted that if she did not like what he did, she could go back to her home town.

In these ways, then, women spoke of how gender defined their family responsibilities and work loads. They were responsible for household tasks and spent a considerable amount of time in preparing food, collecting water and fuel wood and caring for their children (Ardayio-Schandorf, 1993; Avotri & Walters, 1999a). In these tasks they received little help from men. At the same time they were responsible for food production and they assumed much of the financial responsibility for their family. Apart from managing to feed and clothe their children—a struggle for a number of women—they also worked hard to find the money for school fees. They felt that a better education might give their children a better future. This led them into several different income-generating activities, yet they faced constant worry about having enough money. It is these responsibilities, in an economy that discriminates against women and keeps them in the informal sector, which heightens the sense of contradiction that women experience and that, in their opinion, lead women to ‘think too much’ and ‘worry too much’. They also felt that their heavy work loads and long days of work take a toll on women’s health (Avotri & Walters, 1999a). Gender roles place heavy demands on women, yet also constrain them, limit their control over their lives and rob them of access to resources. It is this contradictory reality that underpins their accounts of their health problems and it stands in stark contrast to biomedical explanations and strategies that emphasise individual responsibility for health.

In talking about the problems women faced, one young woman said that ‘since I was born and knew that I am a woman, I have never been happy’ (Int. 19). Respondents said
that ‘thinking too much’ and ‘worrying too much’ were constant elements in their lives and they felt that this was the source of other low-level psycho-social health problems, such as being absentminded and experiencing difficulty in sleeping. These problems might also assume a more public form; women said that worrying was the reason they sometimes talked to themselves as they walked along the road, throwing their arms into the air like a person who was ‘tying one yam’, a local expression for eccentric or strange behaviour.

While the relationship between a husband and wife is not defined as central (Manuh, 1994; Potash, 1995), women’s ties with their children are strong. Their children were often the focus of their worries. They worried about having enough food for them and being able to pay for their schooling. They worried about the immediate problems of caring for their family and they worried about the future that their children would have.

What I worry about is my children … I think about the future, like, how are they 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 and you don’t have anything, I worry too. You’ll be saying, ‘Ah! Today, I don’t have anything, no food to give to my children’ and all that. They worry me a lot. (Int. 13)

Worries permeated the lives of many women and they worked harder and harder with little sense of advancement.

You don’t get enough even though you work hard … 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. (Int. 36)

Findings ways of earning money was critical. One young woman had tried with little success to trade in a variety of items. Her husband did not provide for her and their two children and she worried about money and not being able to support her family.

I have to think about what to do to take care of the children and myself … Right now that I’m 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)

Women’s roles as informal health care providers is highlighted by a woman with an absentee husband who asked

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)

The problem for widows and other women with no partner was even more pronounced. One woman whose husband had died a few months earlier used imagery of a worried brain that grows bigger than her body:

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. Everytime ‘susu’ [your brain] is always working, ‘susu’ becomes bigger than you yourself. Hmm _______ that is how I live. You know if you are woman and don’t have your needs, you’ll always be worried. (Int. 2)

Not all women carried such a major responsibility for meeting their family’s needs.
Some men were supportive of their wives and there appeared to be instances of joint decision making. There is also some evidence that men are starting to help women with tasks such as fuel wood collection (Ardelayio-Schandorf, 1993). Moreover, men did contribute ‘chop money’ for household expenses as well as their labour. Indeed, the more severe problems faced by women with no partner highlight women’s dependence on men and the importance of marriage. Yet the dominant theme in the interviews highlighted the ways in which women understand their health problems in terms of the considerable financial responsibility for their family that women shoulder with relatively little support from their husbands; it was mainly women who worried about household finances and struggled to provide for their children. We see how women linked the psycho-social health problems they described—‘worrying too much’, ‘thinking too much’ and associated symptoms—with the culturally defined responsibilities they faced as women. There was little reference to the biological basis of their health problems and neither did they blame themselves for the problems they faced, both of which are more frequent reactions in the West.

**Women’s Insecurity in their Relationships with Men**

There is a strong tradition of economic activity among women in Ghana and some operate as powerful market traders. Yet social and cultural constraints keep women in marriages which may be marked by infidelity or abuse—another element of the ‘contradictory reality’ they face. Women are expected to marry and to bear children, especially sons; single women and women living alone face economic problems, are stigmatised and also seen as threats to other women. It is perhaps not surprising that, as well as giving voice to their worries about financial insecurity and how they could support their family, women also worried about the stability of their relationships with their husband or partner. Their fears emerged at several points in the interviews. Cultural expectations and economic constraints meant that women were unlikely to leave their husbands, yet insecurity marked their relationships. They feared that their husbands might leave them or might take another wife. Such fears and women’s lack of control over resources also meant that they would tolerate physical and verbal abuse.

The infidelity of their husbands was a major source of worry and concern for women. One woman said her husband’s infidelity had resulted in the birth of two children, each with a different woman in the town. It worried her that her husband was still ‘sleeping in town’ and returning the next morning. She said that it worried her so much that she had been having severe headaches and was losing weight. In addition to other worries, she mentioned the fear that appeared in many women’s accounts—that their husbands might contract AIDS. Women felt vulnerable, that their health was at risk, especially when their men came home late or showed other signs of infidelity.

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)

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’:

Me for instance, like my husband and I … 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)

She believed that such experiences led to ‘thinking too much’ and could give women high blood pressure.

Another woman who had not seen her husband for the past seven years talked about how some men deserted their wives, which in turn affected women’s mental health:

Sometimes, you see, travelling is common now, and you’re with your husband, fine, and then he tells you. ‘Stay here oooh, you and the children, I’m travelling, when the month dies [ends], I’ll come back’ … 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)

Abandonment, feelings of betrayal and lack of social support from partners were seen by women as sources of women’s poor psycho-social health. They explained that their husbands could divorce or leave them for flimsy reasons. 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 nominal reasons for a woman to be physically or verbally abused, divorced or abandoned by her husband. If they failed to give birth to male children their husband might divorce or leave them. Some women were deserted for no apparent reason. One woman said her husband ‘left us just like that’ (Int. 67) 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 deserted by their husbands for other women.

It is hardly surprising that, for the most part, women’s impressions about marriage tended to be negative. One woman’s words capture the general feeling that 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)

For many women, then, marriage was an institution which exposed women to insecurities and uncertainties in life, and which prompted some of the illnesses they
experienced. One respondent described how the break up of a marriage could lead to a woman worrying and ‘thinking too much’: ‘... 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). This particular woman believed that she had suffered from hypertensions because of the behaviour of her former partner and she told how her partner had left her immediately after her second baby was born. Another respondent believed that some women suffered from mental health problems 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)

One woman had already been married three times and was in a bad marriage at the moment. This made her worry constantly and she felt it was the reason for the severe headaches, body pains and stomach aches she suffered. She also experienced difficulty sleeping. Another woman talked about a friend who had lost a lot of weight as a result of ‘thinking too much’ about her husband’s infidelity: she ‘thinks until she has even lost her structure, she has lost so much weight ... her husband has been flirting with a flirt [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). Several women said that these kinds of worries caused their weight loss. One woman said ‘I became like a strand of a broom, I became thin, because I was always worried’ (Int. 19).

Losing weight is an important issue—to most Ghanaians, unlike most women in the West, thinness indicates suffering, hunger, malnourishment or illness.

It is understandable, then, that because of the behaviour of their partners women would worry and ‘think a lot’, and they were often on their guard fearing that they might be deserted. One respondent explained that women would become concerned when their husbands started to behave differently 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)

This woman said that women could begin to behave in unusual ways as a result of thinking or worrying 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 strangely]. (Int. 15)

In Ghanaian society there is a very strong expectation that woman will marry and have children. But the women in this sample often felt ambivalent about marriage. They felt that their relationships with their husbands affected their mental well-being, yet the fear of being deserted meant that women might tolerate abuse and unhappiness in their marriage. The authority and control of their husbands was thus reinforced.
Physical and Verbal Abuse

Violence against women has received relatively little attention in Ghana (Ofei-Aboagye, 1994) and in other developing countries (Heise, 1993; Heise et al., 1994) and prevalence rates probably greatly underestimate the magnitude of the problem. Studies in a number of countries suggest that it is a significant social and health problem and it has been linked with cultural, economic, legal and political features of societies. In reviewing the existing research, Heise et al. (1994, p. 1170) argue that several factors help to perpetuate this abuse of women: ‘legal systems that discriminate against and fail to protect women, economic structures that disempower women, cultural systems that legitimize violence, male control of female behaviour and political realities that ensure that women’s needs and concerns are marginalized in the corridors of power’. Together, these mean that the ability of women to leave abusive marriages is limited, for there are few social supports and little recognition of the problem.

Abuse by partners was not a prominent theme in women’s conversations in this study, though some of the women did complain that their husbands physically or verbally abused them or else did not talk to them. A young woman mentioned that violence towards women was quite common, though she said that many women were unwilling to talk about it. She told how she had miscarried after she was severely beaten by her husband:

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)

She added that she had also been physically abused by her husband’s nephew who was living with them. Another young woman said that her lover beat her and had 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).

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 talk to them despite the fact that they lived under the same roof. One respondent said that she found it very difficult to approach her husband with a problem and this made her very unhappy:

Yes, we don’t talk 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 talk 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 that I’m worrying him too much, and this worries me a lot. And because of that I’m not happy ... he tries to provide for my needs, [but] we don’t communicate. (Int. 55)

Another respondent said that what concerned 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 [out] to dinner, he doesn’t even tell me ... 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)
Her husband, an alcoholic, spoke to her only when he was drunk. On these occasions he would come home to insult her: ‘... 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).

A woman who lived in a house with several tenants said her husband was often abusive and she told what happened when she had prepared a meal that had not pleased him:

… yesterday we prepared ‘banku’ [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 at me, the whole house was hearing what was being said, 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)

Even though 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 … if there’s no food on the table in the afternoon, he’ll get angry, but he’s not giving me money. (Int. 36)

Men’s control of resources, together with their authority within the family, render women dependent on men and they find it difficult to leave abusive marriages. This is likely to be particularly problematic during a woman’s childbearing years, given the cultural emphasis placed on this aspect of women’s roles. Some writers have noted that women might gain a greater freedom in their middle years and are better able to leave, relying on their children for support (Potash, 1995). However, many of the women in this study spoke of how even their older children continued to be dependent on them.

Conclusion

In discussions of women’s health in the developing world, the primary emphasis has been on their childbearing role; much less attention has been directed towards women as workers and as wives and mothers, and to the ways in which their lives are shaped by gender relations. While the dangers associated with childbirth should never be dismissed (Lewis & Kieffer, 1994) it is important to recognise other ways, too, in which women’s health is diminished. Listening to Ghanaian women’s own accounts of their health helps us to develop a different image of the problems they experience (Brems & Griffiths, 1993). We see the types of day-to-day problems that are common, though too often neglected in discussions of women’s health in the developing world; this is not the language of government reports and clinical evaluations (Murray & Lopez, 1996). Instead, women speak of low-level psycho-social health problems, idioms of distress which reflect and which are attributed to the contradictory demands they face. It is noteworthy that women talked about their health in the context of their day-to-day lives; it was not something that was seen as separate and compartmentalised. Moreover, they seldom made reference to themes that are more common in the West—biomedically
based models and explanations that focus on ‘lifestyle’ issues whereby women are often blamed for behaviours that impair their health.

Many women spoke of worrying and thinking too much and associated insomnia, headaches and weight loss. They explained these in terms of the insecurity and unpredictability that marked their lives in an economic sense and with respect to their relationships with men. The interviews contained many examples of their long days of work and their efforts to support their families (Avotri & Walters, 1999a). It is testimony to women’s persistence and ingenuity that they provided for their families. Yet woven into their accounts were severe and persistent worries about not being able to manage. They worried about their financial insecurity and about the stability of their relationships with their husbands. Gender relations define their responsibilities for their family while at the same time withholding the control and resources they require in order to achieve a measure of economic independence and predictability. They continue to be socially and economically dependent on men. The contradictory reality associated with these aspects of gender have seldom been traced in discussions of women’s health in the developing world.

Their hopes for the future included better education, jobs in the formal sector and access to credit to establish or expand small businesses (Avotri & Walters, 1999b). They felt that these would help to provide financial stability as well as a measure of independence that would change their relationships with men. Moreover, their comments suggest that a ‘free heart’ is to be found in a more equal relationship marked by greater sharing, trust and communication with their partners; a rather different image from the more individualistic definitions of freedom and independence that are often voiced by women in the developed world.

Incorporating women’s voices would allow us to paint a fuller picture of the nature of women’s lives in developing countries, the health problems they experience and the way in which these are linked with the structure of their lives. The accounts presented here suggest that it is important to explore more fully different aspects of gender relations and the ways in which they shape the health of women. Policies have seldom addressed key features of traditional gender roles (Kabira et al., 1997) and the absence of women in decision-making positions means that pressures for gender-sensitive policies are crucial. Community-based research might help to give voice to women’s concerns and encourage their collective representation.

Acknowledgements

The research reported here was funded by the Social Sciences and Humanities Research Council of Canada and the Faculty of Graduate Studies of McMaster University. We appreciate the help we have received from many people. In particular, we thank Susan French and Pamela Sugiman for their feedback during all stages of the research, and Jane Aronson and Chris Sindling for their comments on earlier drafts of this work. We would also like to express our appreciation of the comments of the anonymous reviewers of this paper. Most of all, we are indebted to the Ghanaian women who so willingly gave up their time to participate in the study.

REFERENCES

AVOTRI, J.Y. & WALTERS, V. (1999a) ‘You just look at our work and see if you have any freedom on earth’: Ghanaian women’s accounts of their work and their health, *Social Science and Medicine*, 48, pp. 1123–1133.

AVOTRI, J.Y. & WALTERS, V. (1999b) ‘Ahrewa bebor ball gives you strength, even the weak can become strong’: Ghanaian women’s accounts of coping with their health problems. Manuscript under review.


