“Their Smiles Behind the Tears”

Stressors and Resistance Resources Amongst Mothers of Bolni Village in the Northern Region of Ghana.

A Qualitative Study

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ABSTRACT

Introduction to Study: Addressing the issues of well-being and health for women has become a key concern for many countries, health care professionals and international organizations. Significant progress has been made in developed countries unlike the less developed ones like those in Africa. Many rural women in African countries experience unpleasant social conditions that determine their health, especially those in the poor areas. When it comes to women in Ghana, there is a huge gap between the Northern and Southern Regions. Areas in the North like Bolni village experience a lot of challenges including the quality and extent of health services. In spite of these challenges, many of these women could be thriving and doing well. This study contributes to ongoing studies on the well-being of women in poor rural areas by identifying the stressors and resistance resources that affect well-being for women in Bolni village in the Northern Region of Ghana.

Objectives and Research Questions: The objectives of the study were to understand the factors that influenced the health and well-being for mothers in Bolni village. To address these objectives, two research questions were generated. These were (1) What are the stressors that threaten the well-being of Bolni mothers? (2) What are the resistance resources that foster well-being amongst Bolni mothers? Some policy implications of the findings for promoting health in poor areas like Bolni village were considered as well.

Theoretical Framework: The theory of salutogenesis was used as a guide for this study. It has two core variables; the Generalised Resistance Resources (GRRs) and Sense of Coherence (SOC). Salutogenesis emphasizes the factors that cause health and well-being rather than those that cause diseases in a world where stressors are ubiquitous (Antonovsky, 1979). The study did not only explore the stressors in the lives of the women but also, how the GRRs are applied in coping with the stressors. The Stressors and GRRs helped in understanding the SOC of the women and how this affected their movement towards positive health and well-being.

Methodology: A qualitative research design was used for this study. The methods for data collection included in-depth interviews with participants and key informants and observation. A semi-structured interview guide was used in conducting the interviews. The interview was orally translated from the English language to Kokomba for the

participants by one of the research assistants. The recorded interviews were further translated from Kokomba to the English language. This was done at the end of each interview so as to follow up for more clarifications when needed. Notes were taken throughout the data collection period. All interviews were recorded, transcribed and analyzed using Attride-Sterling's (2011) 6 steps in thematic network analysis as a guide. This was done by classifying the data into basic, organizing and global themes. All the participants (10 mothers) in the village voluntarily participated in the study. Permission was sought from them in taking and using their photos in the study. Ethical clearance was given by the Research Committees (NSD) in Norway and the Ethical Review Committee in Ghana before the study began.

Results and Discussion: The study revealed several stressors that threaten the well-being of mothers in Bolni. Some of these included work overload, climate changes, financial difficulties, motherhood and negative traditions. Despite these stressors, there were resources that enabled many of the women to cope and thrive. They found their coping strengths in resources like supportive relationships, income generating activities, religion and motherhood. Examining the findings from the salutogenic point of view, it was evident that the stressors and GRRs influenced how the women saw their life experiences and how their SOC was shaped by these experiences. The findings revealed that most of the women were able to maintain a balance between the stressors and GRRs which possibly accounted for their strong SOC. This stimulated many to move towards the state of positive health and well-being. Most of findings from the study were also consistent with those from similar studies done in other developing countries like Tanzania, Haiti and India. The findings were also discussed in relation to some of these studies.

Conclusion: In spite of the stressors that threatened their well-being, the women were able to identify resources that enabled them to cope. Most of the women seemed to have a strong SOC that stimulated their movement towards positive health and well-being. Thus, the findings suggested that a strong SOC was central to the movement towards positive health and wellbeing for the women in Bolni. Conducting similar studies on a larger scale will contribute to a deeper understanding of well-being and processes of salutogenesis in the lives of women in poor rural areas of Africa at large.

ACRONYMS AND ABBREVIATIONS

CHPS…….Community-based Health Planning and Services.

FAO……..Food and Agriculture Organization.

GRRs……Generalized Resistance Resources.

HiAP……Health in All Policies.

HP……Health Promotion.

HIV/AIDS…Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome.

IFAD……International Fund for Agricultural Development.

MDGs…….. Millennium Development Goals.

NGO……Non-Governmental Organization.

NSD…….Norwegian Social Science Data Services

OECD…….Organization for Economic Cooperation and Development.

SOC……Sense of Coherence.

SSA……Sub-Saharan Africa.

STIs……Sexually Transmitted Infections.

WHO……..World Health Organization.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Study

A Foreigner once visited one of the remote areas in Africa for a project. Looking at the very low living conditions in the area, she exclaimed "How on earth do they survive under these conditions?" Doing better than could be expected under difficult circumstances is referred to as "Resilience". Studies into resilience started in the 1980s by researchers who mostly directed their efforts towards individuals and children in high risk environments. The primary focus was on risk identification, personal characteristics and protective elements which "demonstrated adaptive capacities under a range of adverse conditions" (McIntosh et al., 2008: 3). Around the same time, the salutogenic model was introduced by Aaron Antonovsky (1979) postulating how in a world where stressors are ubiquitous, focus should be put on the processes which enable individuals to move towards health rather than disease.

Presently, the subject of resilience and well-being is being investigated amongst different population groups. One of such groups is women. Taking action to improve equity in health and to address women's rights to health is one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources (WHO, 2009). Discussions of women's health have been shaped by the concerns of policymakers, international organizations, health care professionals and other experts (Walters, 1992). Whilst significant progress has been made in developed countries, the situation is different for poor and less developed countries like those in SSA. This is due to multiple and diverse constraints such as unequal access to productive resources, services, inadequate infrastructure and geographical location (UN Commission on the Status of Women, 2011).

For women in African countries, the rural dwellers suffer the most from unpleasant social conditions that determine their health. The women hardly have access to resources that facilitate in making their work more productive and easing their heavy work load. They have a lot of responsibilities such as looking after the children and other relatives, preparing the meals and keeping the home. In addition to these, some

of them may be involved in several income generating activities like engaging in small scale trading and working as wage labourers. In the very poor areas which are affected by climate changes, women are left with the sole responsibility of raising the children and farming when the men migrate in search of work (IFAD on Women and Rural Development, 2011).

When it comes to Ghanaian women, there is a huge gap between the northern and southern areas in terms of poverty, including the quality and extent of health services. The regions with the lowest level of health care provision and greatest problems in public health are the Upper West and East, Northern and Central regions. Women here spend more time than urban women in reproductive and household work, including time spent obtaining water and fuel and caring for children and the sick (Ghana Health Service Report, 2011). Women are expected to provide for their families, yet they face economic uncertainty and discrimination in their access to jobs, lands and credit (Avotri & Walters, 2001). Rural women are exposed to risks and adversities that pose a serious threat to good outcomes and well-being yet, many of them continue to thrive and stay well (Bull & Mittlemark, 2010).

It is in light of the above that the study identifies some of the risk factors that threaten the well-being of mothers in Bolni village and the resources that enable some of them thrive. This helps in bringing the felt needs of the mothers to bear. It could also help to understand women who may be having similar experiences like those in Bolni village. The findings are discussed from the salutogenic point of view, capturing the role SOC plays in the lives of the mothers and their movement towards positive health and well-being for mothers in Bolni. This study explores the living conditions, stressors and resources of mothers in Bolni village in the Northern Region of Ghana.

1.2 Organization of the Study

The study is organized into seven chapters. Chapter one provides a general overview of what the study is about. Following on in chapter two are the concepts of well-being and health, background to Health Promotion, well-being in Ghana, theoretical framework and literature review. Chapter three presents the background to Bolni village. Chapter four presents the methodology. Chapter five captures the results. The

findings of the study are discussed in chapter six. The last and seventh chapter is on the limitations, recommendations for future research, the summary and conclusion.

1.3 Purpose of the Study

Although studies on the factors that determine health have been conducted, not much has been done in extremely poor rural areas like those in Africa (Bull, 2009). Though most women in such areas go through a lot of challenges, few studies on women who thrive in such areas exist. As noted by Whitehead (1992), links between poverty and ill-health in the West have been extensively documented, including some accounts of how material deprivation is experienced by women themselves. There is however less detailed and reliable information on developing countries. This study contributes to the knowledge base in health promotion and adds to the resistance resources borne out in on-going studies for women in poor rural areas in Africa.

Again, this study could be relevant to contemporary studies on the subject of thriving and well-being. As noted by Compton (2005), scientific research is revealing how important positive emotions and adaptive behaviours are to living a satisfying and productive life. Most importantly, the findings from the study could positively impact health policies and may be useful to stakeholders of health, Health Promoters, NGOs and Health Research Institutions in promoting health effectively in villages like Bolni.

Finally, this study was as a learning experience for the researcher. It created the platform to learn and understand the lived experiences on well-being of women in Bolni village.

1.4 Research Objectives

The general objectives of the study were to understand the factors that influenced the health and well-being of mothers between 25-45 years in Bolni. The study focused on the stressors that threatened their well-being and identified the resources used in coping with the stressors.

1.5 Statement of the Problem

One of the well-known factors that influence the well-being of people in developing countries is poverty. This has often resulted in a very low standard of living for poor rural areas in these countries compared to the developed ones. The basic amenities of life such as running water, proper infrastructure and health facilities are hardly available. These are very important to promote the health and well-being of people.

Bolni is one of such poor villages in the Northern region of Ghana. The village has no health facilities and lacks basic resources for daily living. For the women in Bolni, life becomes even more challenging as they are overburdened with many roles and responsibilities. They are likely to be held back by limited control over resources and unequal property rights. In such rural areas, patriarchal relations are strong and men continue to control most productive resources such as land, livestock, tools and means of transport. They retain most of the proceeds of their work while expecting their wives to meet most of their family needs through food production and earnings from income-generating activities (Koopman, 1995 in Avotri & Walters, 2001). In the midst of these adversities, many of these women, mostly mothers may be thriving and staying happy. However, not much attention is paid to women in such poor rural areas especially, in Ghana. A better understanding of the contributing factors that make these women thrive and the stressors that threaten their well-being will better inform health promotion policies and guide effective practice in these poor rural areas particularly, in Ghana.

1.6 Research Questions

The research questions used in this study are as follows

1. What are the Stressors that threaten the well-being of Bolni mothers?

2. What are the Resources that foster well-being amongst Bolni mothers?

1.7 Definition of Concepts

The study revolved mainly around the concepts of Stressors and Resistance Resources amongst Bolni mothers. These concepts and their relation to the study are explained below, with reference to the salutogenic model which will be laid out later in chapter two.

Stressor (s): This is "a demand made by the internal or external environment of an organism that upsets homeostasis, restoration of which depends on a non-automatic and not readily available energy expending action" (Antonovsky, 1979:72). In this study, stressors mean the challenges or factors in the external or internal environment of Bolni mothers that negatively affect their well-being.

Resistance Resource(s): In this thesis, resources will be captured by the construct "resistance resources" which is a core concept in the salutogenic model. A resistance resource is a "physical, artificial, material, cognitive, emotional, value-attitudinal, and interpersonal-relational or macro socio cultural characteristics of an individual, primary group, sub culture or society that is effective in avoiding or combating a wide variety of stressors (Antonovsky 1987:105). Resistance resources in the study refer to the resources Bolni mothers use in combating or managing the identified stressors.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction to the concepts of well-being and Health

Well-being has been a concern to society since time immemorial. In an attempt to achieve effective well-being for people, the concept was regarded from many perspectives in the Western world (Petterson, 2006). Subjective well-being deals with "studies that investigate the causes, predictors, and consequences of happiness and satisfaction with life" (Compton, 2005:43). It also involves the emotional state of people and how they feel about themselves and their world (Compton, 2005). Subjective well-being is often used as a synonym for happiness (Synder & Lopez, 2007).

As popular as the subject of well-being has become in contemporary studies, one of the major problems was how to measure well-being. A solution to this was when researchers gave way for participants to define well-being themselves. Since the issue of well-being is subjective, it became imperative to measure it with "subjective reports" (Compton, 2005: 44). This means that well-being should be studied from the perspectives of the subjects being studied.

Well-being and Health works hand in hand. Health is generally seen as a state of well-being. For example, health is seen as a state of physical, mental, and social well-being (Dorland's Medical Dictionary, 2007). Health is a complex concept with different perspectives. These perspectives vary in scope and context (Spector, 2013). Health could be defined from social, cultural, biomedical or spiritual perspectives (Eriksson, 2007). One important determinant of how health promotion is seen is the way health is defined "at least in relation to how the word is used in the term health promotion" (Green & Raeburn 1988:153). The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1948:100). This definition has had criticisms based on the notion of completeness (Green & Raeburn, 1988). However, an important aspect of this definition is health being more than the absence of disease and extends to include physical, mental and social well-being.

From the biomedical perspective, health and illness "are, surely, simply biological descriptions of the state of our bodies" (Bury, 1997:356). One of the biomedical assumptions on health is that disease is a temporary organic state that can be cured by a medical intervention (Bury, 1997). This perspective has been criticized for having a negative definition (the absence of disease) because it focuses primarily on the "curing", reducing the dependence on individuals own accounts of health (Green & Raeburn, 1988; Bury, 1997).

The social perspectives on health are concerned with the social influences and origins of disease rather than exploring its organic manifestation in the bodies of individuals. This perspective is concerned with among others, the role the "sick" person plays in society and how the subjective experiences of health are created (Bury, 1997). From many spiritual and cultural perspectives, health is seen as being free from and the absence of evil. Thus, health is synonymous to day (good light) whilst illness is synonymous to a punishment for one's evil deeds (Spector, 2013). Some of these perspectives are captured in section 2.4.1 on some of the cultural perspectives on health.

Given the diversities in the definitions of health, the researcher infers from the salutogenic perspective on health for this study. Antonovsky explains health using the "health ease/dis-ease continuum" (1987). According to him, health is "the state of that system we call human organism, which manifests a given level of order" (1996:172). Thus, individuals go through stressful events in life that determine their placement on the "health ease/dis-ease continuum". On this continuum are, (H-) representing the total absence of health and (H+) representing total health. Stressors that are poorly managed will lead to a negative (H-) placement on the health ease/dis-ease continuum. However, those that are well-managed will lead to a positive (H+) placement on the continuum (Antonovsky, 1987). The salutogenic orientation in this sense basically deals with the ability of people to manage their stressors and move towards the healthy end (H+) of the continuum (Antonovsky, 1996). By taking this perspective for the study, the stressors that negatively affect the health of mothers in Bolni village are highlighted. Most importantly, the resources used in managing these stressors and how this affect their movement towards positive health and well-being is shown in this study.

2.2 The History of Health Promotion

Health Promotion is defined as the process of enabling people to increase control over and to improve their health (Ottawa Charter, 1986). It involves the movement towards a positive state of health and well-being. Health Promotion connotes a positive construct where people are to participate and be given "as much control as possible to achieve health or a higher state of wellness" (MacDonald, 1998:27).

Health Promotion as an expression began when it appeared in a document by Marc Lalonde, the then Canadian Minister of Health and Welfare in 1973. This document created a shift from attributing the causes of all diseases to medical origins to non-medical origins (MacDonald, 1998). The Lalonde initiative prompted the World Health Organization (WHO) to hold the ever first conference on Health Promotion in Alma Ata, Russia in 1978 which birthed the Alma Ata Declaration on Primary Health Care. Several other conferences were held in different countries. The popular and first international conference was held in Ottawa, Canada in 1986. This produced the popular Ottawa Charter that is known as the "corner stone for the establishment of the Health Promotion field" (Samdal & Wold, 2012: 5).

The second international conference was held in Adelaide, Australia in 1988. It emphasized the need for creating healthy public policies in health promotion. Following was the third conference in Sundsvall, Sweden in 1991. This conference laid the foundation for the principles in building supportive environments for promoting health. In 1997, the fourth conference was organized in Jakarta, Indonesia. Here, the need to create partnerships and strategies in achieving successful health promotion was emphasized. Mexico hosted the fifth conference in 2000 where the issue of reducing inequalities in health was addressed. By this, incorporating strategies for health promotion at all levels of policies was seen as very important. The sixth global conference was in Bangkok, Thailand in 2005. It focused on factors that determined the health of an individual. The seventh conference on promoting health and development was held in Nairobi, Kenya in 2009 (Samdal, & Wold, 2012). The most recent conference was held in Helsinki, Finland in 2013 which focused on the implementation of "Health in All Policies" (HiAP).

Today, Health Promotion is a celebrated subject of many books, articles, and courses for students and conferences. It has also become an interesting area of research for

many research institutions like the Department of Health Promotion and Development at the University of Bergen, Norway.

2.3 Some Core Values of Health Promotion

Health Promotion has some core values that make it distinct as a subject and a profession from others. Values are generally core beliefs that guide the actions and decisions of individuals. The values in health promotion are the beliefs that guide its practice. In developing these core values, five key strategic areas were identified. These were creating supportive environments, strengthening community action, building healthy policy, developing personal skills and to reorient health services (Ottawa Charter, 1986). Some of these core values are explained below.

2.3.1 Empowerment

This is "a process through which people gain greater control over decisions and actions affecting their health" (Health Promotion Glossary, 1998: 6). Naidoo and Wills (2000) distinguish between two types of empowerment. The first being self-empowerment is used to describe approaches which use non-directive and client-centred approaches aimed at increasing people's control over their lives. The second is community empowerment which involves active participating communities which are able to challenge and change the world about them. Empowerment comes in different forms for different people and contexts. Thus, it is multi-dimensional and occurs within economic, psychological, social, spiritual and other dimensions (Rappaport, 1984, 1987; Page & Czuba, 1999). Empowerment in Health Promotion implies enabling individuals to address the factors that determine their health by increasing their control over these factors (Frankish et al., 2006). The essence of empowerment is that it cannot be bestowed by others but gained by those who seek it. Hence, those who wield power like health practitioners and those who seek it like clients must work to create the conditions to make empowerment a possibility (Laverack, 2006). In patriarchal rural areas like Bolni village where men wield the most power, the campaign towards empowering women will work best when the men who wield the most power are involved in the process.

2.3.2 Participation

The Ottawa Charter (1986) emphasizes social, personal and physical resources in promoting health as a responsibility for all. This implies the active participation of all those concerned in the process of health promotion. Participation is closely linked to empowerment and also aims at developing a concrete and effective public participation. People's participation in the processes of health is a means of empowering them to take control over the factors that determine their health. According to Naidoo and Wills (2000), participation is "the involvement of people in the community in the formal processes of policy making and implementation. Participation can vary from high to low levels of involvement" (p.201). Thus, identifying and defining problems, decision making and creating interventions are to be done individually and collectively. This promotes a sense of ownership and facilitates the sustainability and attainment of project goals (Naidoo & Wills, 2000). For instance, in promoting health in a rural setting, one could emphasize the principle of participation by organizing local meetings with the rural folks and local government to prioritize needs and draw interventions. In this case, the health promoter is not working "for' but working "with" the people.

2.3.3 Health Equity

"Equity means fairness. Equity in health means that people's needs guide the distribution of opportunities for well-being" (Health Promotion Glossary, 1998:7). Health equity also refers to social justice in health (Bravemen et al., 2010). This means the differences in societies that privilege some group of people and oppress others need to be exposed, clarified and eliminated (Collins, 1998). This value aims at achieving greater equity in health between and within countries and population. It is based on the premise that individuals have the equal opportunity to develop and maintain their health through a just and an equal access to health resources (Health Promotion Glossary, 1998). Health equity is often confused with health inequality which is about measurable variations in health status. Whilst health inequalities could be attributed to factors like biological differences and the health choices people make, health inequities are avoidable through fairer distribution of opportunities and resources (Health Promotion Glossary, 1998). It is important to note that health inequalities are not usually considered unjust. For instance, the old and elderly people

in society risk having poorer health than young people. Addressing issues of health inequities requires not only making a significant impact on the people who make up a group but also, addressing their real needs (Banks, 2012). This also involves working with the population as a whole in the context of their everyday living rather than focusing on people at risk for specific diseases. This enables people to take control over and to be responsible for their health as an important component of everyday life: both as spontaneous and organized action for health (WHO, 1984).

2.3.4 Sensitivity to Cultural Diversity

Culture in itself has no universally accepted definition just like health. However, Green and Kreuter (1993) argue that there is a general agreement that culture is learned, shared and transmitted from one generation to the next. It expresses the ways of life and beliefs of a group of people. Developing awareness of the social and cultural diversity in all aspects of health promotion demands of Health Promoters to learn about the cultural beliefs of the community in which they find themselves. In doing this, Health Promoters could even participate in the cultural events of settings where they practice. Learning their language could be of great help in communicating with the communities, but where this becomes a barrier, a trained interpreter could be employed to help (Clark, 2002). Being culturally competent to Campinha-Bacote (1994) means that health care providers must become sensitive to and reflective on their personal culture as well as their client's culture. Thus, Health Promoters must be familiar with their cultural beliefs, behaviours, attitudes and how they affect the opinion of others.

2.4 Well-being/Health in Ghana with Particular Reference to Women

What factors influence your well-being? This question could generate an answer based on a lot factors. These factors could range from education, income, behaviour, genetics, cultural beliefs to the environment in which you live. For instance, the forces of culture are somehow behind the different explanations given to well-being/health today. Individuals from different cultural backgrounds make different attributions of health, diseases and their symptoms. These attributions become vital in forming their beliefs on health and illness (Murguia et al., 2003; Furnham et al., 1999). For

example, amongst the Latino population, attributional equity is believed to the cause of health and illness. This means an illness could be a punishment from God for wrong doing. They often rely on the services of the "herbalista" (herbalist) and spiritual forces like the "santeros" who represent the priests of Santeria using local rituals and the saints of the Catholic church (Murguia et al., 2000; Vaugh et al., 2009). Likewise, African Americans in the United States are likely to attribute health to external factors like God and believe in the healing power of prayers. However, the Anglo Americans are more likely to attribute health to traditional western beliefs like individual responsibility for health and illness (Klonoff & Landrine, 1996; Vaughn et al., 2009). Recently, many have come to believe that staying healthy could be attained without reference to deities, families or communities (Landrine & Klonoff, 1992; Vaughn et al., 2009). Some of the factors that may influence well-being and health in Ghana and particularly for women are seen in the following.

2.4.1 Cultural Beliefs

In Ghana, health and illness are generally deemed as private issues which are discussed behind closed doors. Some believe being healthy or ill depends on one's relationship with God. Thus, an illness could be seen as a result of a curse or the consequence of negative choices in a person's relationship with God. In areas where they lack medicine and trained doctors, they are likely to turn to traditional and spiritual cures, using religion and appealing to their ancestors (The African Guide, Ghana; People and Culture, 2014). Socio-cultural factors influence the use and non-use health facilities in developing countries. Factors such as sex differences and gender roles create health related outcomes and options for women (Bazzano et al., 2008; Dako-Gyeke et al., 2012). For instance, in the Ghanaian culture, pregnancy is seen as a potentially dangerous period that needs spiritual protection. Hence, the care for pregnant women comes from a lot of sources such as economic, medical and psycho social support. The numerous churches in Ghana today have given women a new haven to seek protection from witches, wizards and other "evil spirits" (Simkhada et al., 2008; Dako-Gyeke et al., 2003). It is also important to note that the urban areas are well equipped with most hospitals and pharmacies. On the contrary, the rural areas do not usually have these modern health facilities. People in these areas either rely on traditional medicine or cover long distances to access health care (Ghana Demographic and Health survey, 2003-2004). However, these areas are being

prioritized with programs like the Community-based Health Planning and Services (CHPS) that educate communities on health issues (Ghana CHPS, 2009). To a large extent, cultural beliefs influence the way some Ghanaians view health or well-being.

2.4.2 Maternal Health

The well-being and health for women in Ghana particularly centres on reproductive health amongst others. MDG goal five aims at improving maternal health across different countries. Maternal deaths in Ghana are declining but at a slow rate. In 2005, 503 deaths/100,000 live births were recorded. This dropped to 451 deaths/100,000 live births in 2008 (National Development Planning Commission, 2010). Though there are policies like the National Health Insurance Scheme (NHIS) that cover neo- and antenatal care, only 35% of all deliveries were attended by qualified doctors as at 2008. The rest of 75% occurred at home or with traditional birth assistance (Salisu & Prinz, 2009). Every week, 75 women in Ghana die from pregnancy-related complications and child birth (Oxfam Annual Report, 2012-2013). In 2010 and 2011 alone, Ghana recorded 894 and 1,022 maternal deaths respectively (Ghana Health Service, 2011). These statistics have significant geographic variations. The Northern region and rural areas of Ghana are most affected (Ghana Statistical Service, 2009).

2.4.3 HIV/AIDS

The sexual disempowerment for women and gender disparities increase their vulnerability to STIs. Coupled with the lower levels of literacy and education for women in Ghana, they are poorly informed on prevention strategies (Dixon, 2012). For instance, the current HIV epidemic estimates indicate that 225,478 people with 100,336 males and 125,141 females have HIV (Ghana AIDS Commission, 2013).

The HIV rate in Ghana increased in 2003 with 3.6% of the population being infected. This dropped to 2.9 % in 2009 (Ministry of Health, 2009). Women infected with the virus make up 60% with 1.9% infection rate amongst pregnant women in 2008 to 2.9% in 2009 (National development Planning Commission, 2010). Comprehensive knowledge and strategies to reducing the risk of getting HIV includes the usage of condoms and limiting sex to a single uninfected partner. Only 19% of rural women and 32% of urban women were considered to have this comprehensive knowledge (Ghana Statistical Service, 2009).

2.5 Theoretical Framework

2.5.1 Salutogenesis as a Theoretical Framework

Theories in qualitative studies provide overall orienting lens for conducting a study or research (Creswell, 2009). The Salutogenic model is used as the theoretical framework from which the study is examined. Salutogenesis (origin of health) was developed by Aaron Antonovsky in the late 1970s. It derives from interviews of Israeli women with experiences from the concentration camps of World War II who in spite of this hardship remained healthy (Antonovsky, 1987). Salutogenesis is conceptually defined as the" process of movement towards the health end of a health ease/dis-ease continuum where health ease is at the optimal end of the continuum and dis-ease, at the unfavourable end" (Antonovsky, 1979:182-192). The Salutogenic model focuses on the factors that determine the extent to which people become healthy and experience well-being rather than pathogenic, which focuses on the factors that cause diseases (Green & Tones, 2010). This also reflects the very essence of health promotion captured in the Ottawa Charter, (1986) as health being a resource for everyday living and not the objective of living.

The core variables of Salutogenesis are Generalized Resistance Resources (GRRs) and Sense of Coherence (SOC). GRRs are generally resources that help people to cope successfully with stressors. To Antonovsy, they refer to "a property of a person, a collective or a situation which, as evidence or logic has indicated, facilitated successful coping with the inherent stressors of human existence" (1996:15). Some of these GRRs include money, self-esteem, social support, hardiness and intelligence (Antonovsky, 1979). The SOC is a "generalized orientation toward the world which perceives it, on a continuum, as comprehensible, manageable and meaningful" (Antonovsky, 1996:15). The strength of one's SOC determines their location on the health ease/dis-ease continuum.

The comprehensibility component of the SOC refers to "the extent that one has a dynamic feeling of confidence that stimuli from internal and external environments are structured, predictable and explicable. Manageability expresses the belief that resources are available to one to meet the demands of the stressors. Meaningfulness connotes making sense out of life experiences; that the demands of life stressors are worthy of investment or engagement" (Antonovsky, 1987:16-25).

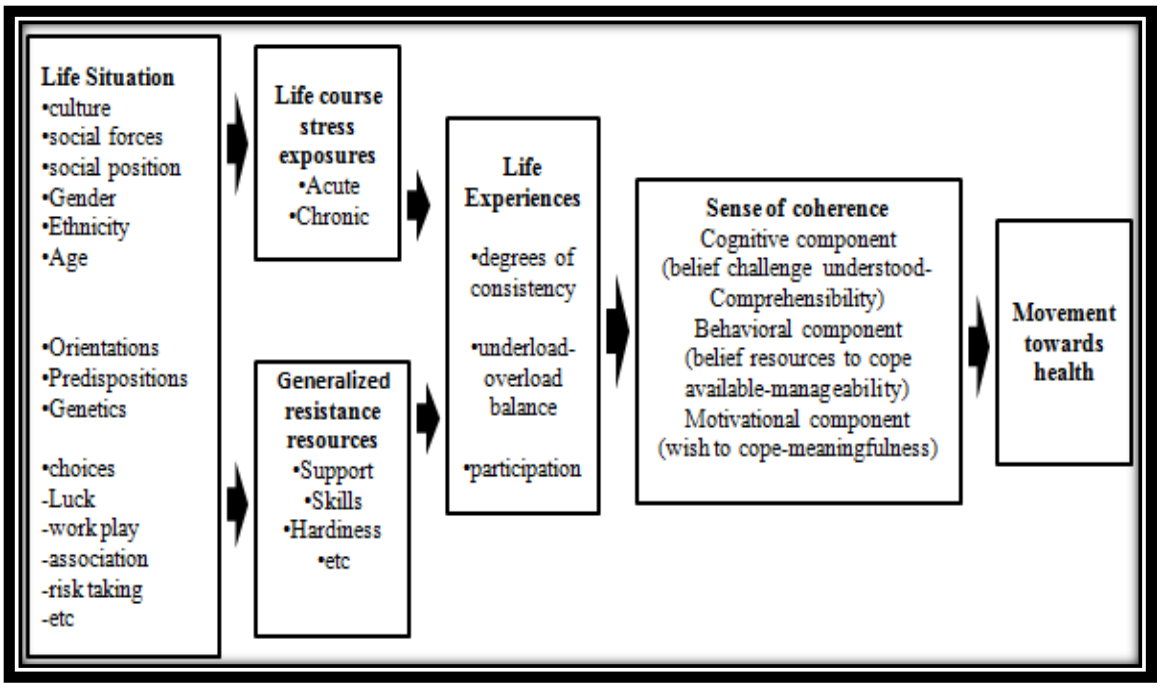

Figure1: The Salutogenic Model **(An Adaptation of Mittlemark, 2010).**

As illustrated in Figure 1, individuals may find themselves in all sorts of life situations shaped by culture, social forces, gender, choices, luck etc. Variables like gender and genetics cannot be controlled by people. However, others result from choices that can be controlled like work and association. Whatever these life situations may be, they generate both Stressors and GRRs. The stressors which could be acute (short lived) or chronic (long lived) have the potential of threatening the well-being of people. However, they are at the same time exposed to GRRs like social support and hardiness which could be used to cope with the stressors. The ability to maintain a balance between these two (Stressors and GRRs) goes a long way to affect how individuals view their life experiences. One attains some degree of consistency when the consequences of life experiences become predictable. The greater the consistency, the more predictable they become (Antonovsky, 1987).

Again, an under load balance could be experienced when the life experiences result in more resources and less risk stressors. An overload balance is when one encounters more stressors over resources. Undergoing these life experiences then calls for solving problems and tasks posed by the experience; that people have performance responsibility that they do or do not do will affect the outcome of the experience (Antonovsky, 1987). This leads to participation in "socially valued decision making" (Antonovsky, 1996:15).

These life experiences turn to shape one's Sense of Coherence (SOC). The stronger people's SOC, the more likely they are to engage in health promoting activities. Thus, they believe and understand that life is meaningful and this gives them a good reason for wanting to be healthy (Comprehensibility). They then search very hard for coping resources (Manageability) that are potentially available to manage the stressors as they understand that these stressors are challenges worthy of investment (Meaningfulness) of energy (Antonovsky, 1996). Meaningfulness is a very important component of the SOC. It is the driving force of life that enables one to search for resources to strengthen the other dimensions; comprehensibility and manageability (Lindstrom & Eriksson, 2010). A strong SOC places or moves one towards the ease end of the health continuum. However, a person with a weak SOC is less successful at stress management and moves towards the dis-ease end of the health continuum (Antonovsky, 1987). Other assertions made by Antonovsky (1990, p.78) on the SOC include among others:

- SOC leads one to engage in health promoting behaviour, for instance through attitudes.
- SOC leads one to interpret a stressor as ordered.
- SOC leads one to search one's repertoire for GRRs that are appropriate for the specific situation, including the resources available through one's network, thereby giving a flexible rather than rigid pattern of response.
- SOC-induced response patterns cause the brain to send messages to activate appropriate bodily resources.
- SOC opens one up to analysis of the results of one's behaviour and makes one ready to redesign response as needed.

2.6 Introduction to Literature Review

Here, the researcher presents some literature on the stressors and resistance resources that affect the well-being of individuals in general. References are made to the stressors and resistances resources affecting the well-being of women in poor rural areas in Africa. In this regard, the researcher often refers to the master's theses of Kanyeka (2010) and Andvik (2010) which formed part of the research project "Social Determinants of Health in Very Poor Ruralities" (Bull & Mittlemark, 2010). The

theses present material from in-depth qualitative studies with women in Tanzania and Ghana, parts of which has been published in peer-reviewed summary papers (Bull et al., 2010; Bull, Mittelmark. & Kanyeka, 2013).

The researcher is however aware that master's theses do not qualify as scientific papers. However, literature on stressors and resources of well-being for women in poor ruralities, with a salutogenic perspective, is so scarce that the choice was made to include these two master's theses in the reference material. The reader should keep in mind that the full theses have not been peer-reviewed.

2.7 Literature on Stressors

2.7.1 Financial difficulty

This is considered one of the factors that threaten the well-being of individuals. Cross-cultural studies indicate there is a relationship between income and subjective well-being in various countries (Dierner & Biswas-Diener, 2002). This suggests that having more or less of money could affect one's well-being. Compton (2005), reports that "living in a wealthier country and having more money tend to increase happiness" (p.59). However, studies have also shown that those who place a high value on money are less satisfied with their lives than others (Compton, 2005). Thus, where money may increase the level of well-being for people, it could also be a major stressor.

Poverty or financial difficulties seriously threaten the well-being of women in rural areas. A study conducted by Avotri and Walters (1999) on women's own concerns about their health in the Volta Region of Ghana revealed that finding ways of earning money was very critical for the women. The inability to secure enough money for the family's upkeep was a great source of worry for the women. This was also coupled with the husbands' refusal to support the home financially. Thus, the women were compelled to move from one income-generating activity to another and worked for longer hours. This is also supported in a study by Bull (2009), on the social determinants of health in very poor ruralities. The study showed that, it was unlikely for people to have a regular income in poor rural areas however, the women often combined several activities to create a living in whatever means possible. Generally,

people in wealthy nations are happier than those in impoverished nations (Snyder & Lopez, 2007). For those in the poor nations however, there is a strong relationship between income and well-being. The relationship between these two is rather insignificant among the affluent (Snyder & Lopez, 2007).

2.7.2 Unemployment

This stems from the fact that most people establish their income from various jobs that they engage in. The Well-being Aggregate Report (2011) by the Qualitative Euro barometer Studies (Conducted amongst 15 member states of the European Union) indicated that unemployment could have a negative impact on well-being. This reflects in people having negative perceptions about the one unemployed, negative feelings of boredom and depression. Unemployment was seen as a factor that could put a strain on individuals' relationship with their families. On the other hand, female respondents in the study saw financial security or independence as very important. They reported that they gained a sense of stability, peace of mind and serenity when they felt financially independent. This meant that they were free in their financial choices and not to depend on anyone. Thus, being unemployed with no financial security made the women vulnerable.

According to the compendium of OECD well-being indicators (2011), experiencing unemployment is one of the factors that have the strongest negative impact on people's subjective well-being. The effects are much larger than the income loss associated with unemployment. Evidence also shows that the psychological resilience to unemployment is low and the impact persists over time (Dolan et al., 2008; Compendium of OECD well-being indicators, 2011).

2.7.3 Work overload

In most rural areas in Africa, this is a factor that seriously threatens the well-being of women. A study by Avotri and Walters (2001) on Ghanaian women talking about their health and their relationship with men supports this assertion. The study revealed that the women spoke of the little control they had over their work in addition to their heavy work load. The findings showed that the women felt their work load increased day by day with little or no support from their husbands. Their husbands owned all the resources whilst the women did all the domestic chores. This created a sense of

insecurity and affected their health negatively as they resorted to "thinking too much" (Avotri & Walters, 2001:202).

Kanyeka's study (2010), on resilience among women of child bearing age in Pemba-Tanzania indicated that work overload contributed to the ill-health of the women. The women engaged in longer hours of hard labour (farming and breaking stones) in addition to the chores they had to perform in the house. They had less time to rest and this took a toll on their health. Women in most of the rural areas are so overburdened with domestic chores such that they are unable to maintain a balance between their work and rest (Bull and Mittlemark, 2010; Bull et al., 2013; Andvik, 2010).

A Report on Gender Inequalities in Rural Employment in Ghana (FAO, 2012), indicated that both men and women were involved in productive and domestic chores. However, there was a wide gap in the time allocated to domestic activities. While 65 percent of the men spent between 0 to 10 hours a week on domestic chores, 89 percent of the women spent 10 hours a week or more. The report revealed that this difference accounted for the inability of women to take full advantage of economic opportunities and to participate in income-generating activities. They had no time to develop their capacities through skills, development and education which could reap economic returns and wellbeing (Gender, Equity and Rural Employment Division of FAO, 2012).

2.7.4 Gender roles

Closely related to the above, this defines the workloads and responsibilities of the women. In most rural societies in Ghana, women have the responsibility for household tasks and they spend a lot of time to collect water, fetch fire wood, prepare food and being mothers; caring for the children (Avotri and Walters, 1999). A study on Ghanaian women talking about their health and their relationship with men revealed that gender roles placed a heavy demand on the women. This constrained them, limited their control over their lives and their accessibility to resources (Avotri and Walters 2001). Gendered role differences are seen more in rural communities than elsewhere. Systematic and structural issues in those areas exclude women from leadership positions. Women have been stereotyped into female traditional roles like managing the home and nurturing which makes it difficult for them to take on leadership roles (Gauntlett et al., 2000; McIntosh et al., 2008).

2.7.5 Lack of basic amenities

Basic Amenities like water, housing, health facilities, environmental quality and electricity are vital to well-being due to the impact they have on the quality of life. The Ottawa Charter (1986) outlines some of the fundamental conditions and resources for health as peace, shelter education, food, income and sustainable resources. The Charter emphasizes that improvement in health requires a secure foundation in these basic prerequisites. The absence of such basic amenities may account for the poor living conditions in most rural areas. Housing for instance is central to the ability of people to meet basic needs. Hence, poor housing conditions could affect the health status of people mentally and physically, the relations between household members and the development of their children (Compendium of OECD Well-being Indicators, 2011).

According to Strasser (2003), in countries where the majority of its populace dwells in the rural areas, the resources are concentrated in the cities. This limits the accessibility of the rural dwellers to these resources. This makes accessibility to resources a huge problem in most rural areas and also makes it a major health issue. According to WHO Water Quality and Health Strategy (2013-2020), the quality of water has an important influence on health whether used for drinking, food production, recreational and domestic purposes. Water of poor quality could cause disease outbreaks. Therefore, managing the safety of water promote socio-economic development, supports public health and well-being.

2.8 Literature on Resistance Resources

2.8.1 Supportive social relationships

This is widely seen as one of the strong predictors of well-being. A supportive social relationship is related to better health, successful coping and positive self-esteem (Compton, 2005). This is usually drawn from marriage, association with family, friends, and organizations. Bull et al. (2013), in a paper on assets for well-being for women living in deep in Ghana, Haiti, India, the Philippines and Tanzania, marriage was highlighted as a factor that increased the status of the women. Being in a quality

relationship where husbands were for instance, emotionally supportive and non-violent, faithful and assisted in house chores made the women happy.

In addition to this, people who are married and cohabiting and those who belong to groups are generally more satisfied with life than those who are not (Diener et al., 2000; Csikszentmihalyi & Csikszentmihalyi, 2006). This presupposes that marriage plays a significant role in fostering well-being. However, a study by Avotri and Walters (2001) on Ghanaian women talking about their health and relationship with men in a town in the Volta Region revealed otherwise. Their study showed that women worried that their husbands would desert them or have affairs. Being married in the Ghanaian context may generate happiness but at the same time breed worrying on issues like unfaithfulness. Doing this could certainly be a strain on one's well-being.

According to Csikszentmihalyi and Csikszentmihalyi (2006), people who are socially supported tend to recover quickly from illness. Such people rate themselves happier "in the present when they are with friends than when they are alone" (p.124). Individuals who obtain support from significant others like their supervisors, classmates and co-workers report higher well-being than those with less support.

2.8.2 Religion

This refers to "a spiritual search that is connected to formal religious institutions" (Compton, 2005:196). A lot of studies have indicated that people who are religious and participate in religious activities tend to be physically and mentally healthier. A deep understanding of one's self and life is enhanced by the search for the sacred as spirituality is associated with mental health, parenting, coping and mortality (Snyder & Lopez, 2007). There has been a greater consistency in finding that individuals with greater participation in religious activities generally reported higher well-being than others (Compton, 2005). For instance, people with greater religiosity tend to live longer by having fewer illnesses (George et al., 2000; Compton, 2005). Religiosity also provides social support and a sense of meaning. Compton (2005), notes that people who participate in church activities with "a community of like-minded individuals" is a source of satisfaction and an important factor in physical health (p.199). In difficult life situations, religion through explanations, gives solutions and provides hope. It "supplies a larger perspective on human life and gives explanations

for why unexpected events may occur" (Compton, 2005:200). Being involved in religion and spiritual matters produces happiness. This stems from one's relationship with a higher power (Snyder & Lopez, 2007).

In a study by Kanyeka (2010) on Resilience among Women of Childbearing Age in Pemba- Tanzania, the well-being of women also depended on their religious beliefs. To them, God was responsible for their creation, their lives and decided the timing and occurrence of all life events. To these women, their belief in God accounted for their fortune. In support of this Andvik (2010), in her study on striving and thriving in dire conditions among women in a poor rural district of Ghana revealed that religion was a factor for the well-being of the women. Different religious groups like the Muslims, Christians and Traditionalists lived peacefully together. In spite of this, differences in beliefs and practices between these groups also led to laws that mostly favored the men but negatively affected the health of the women. In a paper by Bull et al, (2013) studying assets for well-being for women living in deep poverty in Ghana, Haiti, India, the Philippines and Tanzania, the women confirmed that traditional beliefs for instance created fear as springing from punishments from spirits or gods. The obligation to render sacrifices to key gods by offering goats and sheep caused increased poverty in poor rural areas. This could be due to the fact that wealth in most poor rural areas is measured in terms of one's possessions of animals and lands. Also, these animals were sold to support other income generating activities. Judging from this, religion could be seen as both a stressor and resistance resource for women in some poor rural areas of Africa.

2.8.3 Good health

This is a factor that influences well-being in a good way. Good health is valued by people all over the world. The Well-being Aggregate Report (2011), a qualitative Euro-barometer study (Conducted amongst 15 member states of the European Union) showed that experiencing poor health caused people to become conscious of health as an element of well-being. The respondents affirmed that it was vital to stay healthy in order to go about daily activities. The lack of health was seen as a barrier to well-being. Also, the Report revealed that an individual's well-being was affected by the health of others especially for those in the immediate family due to responsibilities of

care. For instance, if a mother fell sick, the entire family got affected as she was not able to take care of the family.

Figueras and McKee (2012), in Health, Wealth and Societal Well-being asserted that whether or not people are economically productive, they derive satisfaction from living longer and healthier lives. People value health as it plays a very important role in increasing economic productivity and in turn, national income (Figueras & McKee, 2012). Studies conducted in some rural areas of Africa have indicated that good health is very important for the women. A study by Bull et al., (2010) on poor women in Northern Ghana talking about their happiness showed that good health for the women generated happiness. Their own health and that of their families meant a lot to the women. Other studies (Avotri & Walters, 2001; Kanyeka, 2010; and Andvik, 2010) also support these findings. According to Petterson (2006), the individual in good health is exuberant, vital, feels alive and enjoy the social and psychological benefits of feeling good. Good health sets the stage for "later longevity and resilience" (p. 226).

2.8.4 Income-generating activities

For most rural communities, these activities depend on the existence and use of natural resources. Rural dwellers often depended on this for their continuing development. Natural capital embodies the quantities, qualities and features of land and water. These are noted to be important for traditional businesses associated with agriculture, mining and tourism. However, natural capital accounted for a range of threats such as extreme weather conditions and floods in these communities (Smailes et al., 2005).

Being empowered economically is an important way for securing families' livelihoods. Economic empowerment for rural women could have a positive impact on them through their increased decision-making power in households, communities and institutions, their status, self-confidence, and respect (UN Women Watch, 2011). The compendium of OECD well-being indicators (2011), shows that earnings and the availability of jobs are relevant for well-being. Those societies with high levels of employment are healthier and richer. This is because individuals are provided with a chance to develop their skills and abilities, to fulfil their own ambitions, to build self-

esteem and to feel useful in society. Thus, the availability of jobs increases their command over resources.

2.8.5 Education and Training

Schools play important roles in the development of future generations of citizens and are the focal points for community activities (Gauntlett et al., 2000; McIntosh et al., 2008). This is reinforced through the contribution the institutions make to for instance, the cultural, informational and environmental aspects of rural life and their participation in ceremonial occasions observed within such communities (Squires, 2001). Education has a strong influence on the well-being of people. Not only do better educated individuals earn higher wages but also, they have a higher probability to have jobs (Compendium of OECD Well-being Indicators, 2011). Most rural dwellers may not be earning higher wages due to the low background in formal education. However, it is important to note that formal education may be scarce in such areas but knowledge and skills are acquired in other forms. This is reported in the research report on the Living Conditions and Determinants of Social Position Amongst Women of Child-Bearing Age in poor areas of India, Ghana and Haiti by Bull and Mittlemark (2010). The findings showed that women acquired skills through apprenticeship and passing on of vital knowledge to others through oral tradition.

2.8.6 Personal Control

This is based on the premise that people have some measure of control over personally important issues in their lives. It centres on how people can "influence events, choose among outcomes…and understand and interpret the results of choices (Compton, 2005: 49). People achieve some level of satisfaction and happiness in life when they possess this measure of control. On the other hand, having the desire to achieve complete control over all issues in life could lead to absolute power which is destructive to one's well-being (Ryan & Deci 2000; Compton 2005). Having personal control also involves the ability to own certain assets like land which is very important for women in most rural areas. A study by Kumar and Quisumbing (2011), on inheritance practices and gender differences in poverty and wellbeing in rural Ethiopia showed that female heads that had an inheritance were more likely to be happy about the outcomes of their lives. In terms of measures of long-term happiness, female heads who received inheritance or gifts were more likely to be happy about

their life outcomes. For women in rural Ethiopia, land was an important element in determining long term well-being. Thus, having an asset like land has significant impacts on food and security outcomes.

2.8.7 Positive Self-esteem

Having a positive self-esteem provides one with a sense of meaning and value, the ability to care for others, greater intimacy in relationships among others (Ryan & Deci, 2001; Compton, 2005). It is however important to note that having a sense of self-esteem that is too high could be detrimental to one's well-being. This leads to positive self-evaluations that are based on "unrealistic self-appraisals …vulnerable to self-reproach or self-condemnation (Compton, 2005:48). According to Linley and Joseph (2004), self-esteem rides high when individuals feel included, accepted and loved by those important to them. As a result, much of people's social behaviour aims at increasing belongingness, social acceptance and inclusion. Self-esteem has a significant impact on health directly or indirectly. For example, people with self-respect and value usually look after themselves by adopting behaviours that prevent diseases. However, those with low self-esteem usually agree to interpersonal pressures resulting in unhealthy behaviour (Green and Tones, 2010).

CHAPTER THREE

3.0 THE CONTEXT (BOLNI VILLAGE)

Information on the history and life in the village as a whole was obtained from a personal interview with one of the senior elders in Bolni and from personal observations made by the researcher.

3.1 Location and History of Bolni Village

Bolni village is located in the Nanumba North District of the Northern Region in Ghana. Bolni village is about 12km away from Bimbilla, the District Capital. Found in the Eastern part of Bimbilla, the village shares boundaries with Kariga in the South, Pusiga in the North, with Ganguyili in the west and in the East, with Joukamonando.

The history of Bolni village was accounted to the researcher by N-Gbiir, the senior most of the elders in the village. Bolni was founded by Gnansiin Toonja in the early 1950s. Gnansiin Toonja was known as one of the fearless and great hunters of his time. On one of his hunting sprees, he discovered a thick forest very distant from the main towns. He discovered the forest was a peaceful haven and appropriate for animal hunting and crop cultivation.

Figure 2: Bolni village (left) and some of its members (right).

Some years later in the 1960s, he moved to settle in the forest alone to start farming and hunting. He invited his extended family, wife and children from Kpasanjolbu,

located in the North Eastern part of the Northern Region in the Saboba District to join him. The brothers of Gnansiin Toonja also invited their wives and children. They became the early settlers in the village making them the "Bitindam" (Land owners). Soon, other relatives and friends also joined these early settlers in the forest. The forest later became known as Bolni which means "water zone". This was so because of the presence of a spring that served as the source of water to the people for a very long time. The "Bitindam" (Land owners) belong to the Kukutiib clan of the Kokomba ethnic group. Soon, Bolni village became a cluster of different clans. Other clans like the "Bichamob", "Bikutulb" and "Nankpantiib" settled in the village. They however had to seek permission from Gnansiin Toonja who gave them lands to live and farm on. In order to prevent the men from fighting over each other's wife, Gnansiin Toonja decided the clans should settle further away from the one another. This accounted for the village being made up of smaller settlements even though, they come together to form Bolni as a whole. These settlements are located further from one another. All the settlements have been assigned numbers to differentiate one settlement from the other. (E.g. Bolni No.1, Bolni No. 2, Bolni No. 3 etc.). It was in one of the settlements areas that the study was carried out. To protect the identities of the participants, the specific settlement number is not mentioned.

3.2 Violence and Conflict (The Guinea Fowl Conflict)

Until the death of Gnansiin Toonja, Bolni was a very peaceful village before the Guinea Fowl conflict in 1994-1995. The conflict was the result of a dispute in the market over the price of a fowl. There were also other underlying factors for this conflict. These centred on underdevelopment and poverty in the Northern Region, ethnic and religious differences (Naylor, 2000). Bolni village was affected, many lost their lives and fled the village. It took the efforts of the Ghana Armed Forces and Non-Government Peace Experts from Kenya to restore peace in the Northern Region of Ghana. This was aided with the signing of a peace accord between the warring factions in 1996 (Naylor, 2000).

When the conflict was over, only a few returned to Bolni to rebuild the place. Others moved further to establish different settlements in other towns. For the settlement where the study was carried out, the whole population was about 250 people. The

elder of the village confirmed that there used to be more people but their number reduced after the conflict finally ended in 1996.

3.3 People and Culture

Bolni village has a population of about 250 people. The village is homogeneous with all the people speaking the Kokomba language. There are however a few Fulanis employed as cattle herds for the Kokombas. The people of Bolni celebrate the "Ndiporndaan" (New Year) and "Namiseen" (fire festival) festivals. During these times, they offer sacrifices to thank the gods for a New Year and season. Their staple foods are Tuo-Zaafi and Green Soup, Fufu and Yam.

Bolni is a patriarchal society where the men own and head all the houses. The women have the duty to maintain the houses by cleaning and doing minor repairs. Assets like land and animals are owned by the men. The people in Bolni practice polygamy where the men are allowed to have two or more wives. It was unacceptable for the women to marry more than one man. The village uphold its cultural values in high esteem with some of the values forbidding people to sing whilst bathing and to sweep and whistle in the nights for various reasons. For instance, by singing whilst bathing, foams from the soap could enter into one's mouth and lead to sicknesses. It is also believed that whistling in the night attracts ghosts to the village as one would be disturbing the peace of the dead.

Life in Bolni village is strongly bonded in unity, respect and peace. Children are taught to respect the elderly and women are obliged to be submissive and respectful to their husbands. As a sign of respect, one is required to squat whilst greeting the elderly and not to greet with the left hand as well. The people see themselves as one and offer help to one another in times of need and trouble. A high emphasis is placed on good moral behaviours. However, people who engage in negative behaviours like theft, fighting and immoral acts are punished. Any person caught in any of these unacceptable behaviours is taken to the village head for the appropriate punishment. The punishment takes the form of paying a fine or offering sacrifices to pacify the gods of the land.

3.4 Religion

There are different religions practiced in Bolni. These are Traditional, Islamic and Christianity religions. The Muslims in the village are mostly the Fulanis who do not live together with the people of Bolni. This is because they are seen as migrants. All the religious groups have their different tenets and values they inculcate into their various members. The Traditionalists worship through media like smaller the "N-tingbawa" (Smaller gods) and their ancestors. There are priest and priestesses who carry out sacrifices and deliver messages from the gods to the people. The Muslims worship through Mohammed whilst the Christians worship through Jesus Christ. Despite their religious differences, the people manage to respect one another and live in peace.

3.5 Basic Facilities and Infrastructure

Bolni lacks a lot of basic amenities. This has lowered the standard of living in the village. There is no health facility in the village. Most of the inhabitants depend on traditional medicine from herbs and roots. There are traditional births attendants in the village who help women deliver their babies. In cases of emergencies, the people have to cover a long distance by foot, bicycle or motor (12km) to the district hospital in Bimbilla. This is because there is no road network from Bolni to Bimbilla. There are no toilet facilities and electricity. Torch lights and lanterns are usually used as sources of light in the village. Though the village has a borehole, there is no running water. All the village members depend on the bore hole as a major source of drinking water. The village has one basic school; from primary one to six. There are however few trained teachers in the school.

The houses in Bolni are built with mud, thatch roofing and round in nature. During heavy down pours, the roofs often leak and some of the houses collapse posing major housing challenges to the village. Modern means of communication like telephones and mobile phones are hardly available. Only few of the young men own phones which they go to charge often in Bimbilla where there is electricity. This makes communication with relatives outside the village very difficult. A television set is

owned by only one person in the village. He usually connects it to a car battery and all the villagers are mostly seen in the house in the evenings to watch it.

3.6 Local Administration

The village has traditional leaders who rule over the people. These are made up of the "Utindaans" (Land owners) and heads of the various families who usually act as the elders of the village. The "Utindaan" is selected from the male children of the founder of the village. All those who do not come from the lineage of the founder of Bolni could not become "Utindaans" (land owners). The traditional leaders are responsible for deliberating on issues of concern to the entire village. They act as the arbitrators during disputes in the families. Cases that could not be handled at the family levels were referred to the "Utindaans". Those issues beyond them were also taken to the District Police Station in Bimbilla. There is an Assembly man responsible for channelling the concerns of the people to the District Assembly. The Assembly man also discussed with the people government policies and interventions that concerned villages like Bolni. Thus, it takes the efforts of government leaders and traditional leaders to maintain law and order in Bolni.

3.7 Local Economy

The inhabitants are mostly farmers engaged in subsistence farming. Crops such as cassava and yam are mostly cultivated by the men whilst the women mostly cultivated vegetables like pepper, okra and tomatoes. Crops like maize and guinea corn are cultivated by both the men and women. Most of the young ones in Bolni are initiated into farming by their parents as it is the major means of livelihood in the village. Farming in Bolni is seasonal. Crops are cultivated in the rainy season from May to November and harvesting is done in the dry seasons from December to March.

On special occasions like naming ceremonies and funerals, the women brew "Pito" (Local drink made from millet) for sale. Though, this supports their income, it may not be enough as this is only done on special occasions. The men also rear Sheep, Goats, Guinea Fowls and Hens. This is done to supplement their income when sold.

For the women who do not own and rear these animals, their sources of income are limited to farming. These serve as the main income generating activities for the people of Bolni.

3.8 Grameen Ghana (NGO Working With Bolni Women)

Grameen Ghana (GG) was registered as a Micro-Finance Organization on 8th November, 2001. The aim of the organization is to reduce poverty and promote justice through working in partnership with other organizations and institutions working with poor and vulnerable groups. The NGO also works with communities in the area of Micro-Credit, Food Security and Nutrition and Education. The NGO has partnerships with other organizations like Action Aid, Whole Planet Foundation, and Planet Finance. Their vision is to be a leading provider of financial, social, and economic services to the poor areas in the Northern Region of Ghana. The NGO mostly work with the women in such areas (Mabefam, 2009: Organizational profile of Grameen Ghana).

The operational areas for the NGO are Nanumba North and South, Zabzugu/Tatale, Tamale Metro, Karaga, East Gonja, Central Gonja, Yendi, and Bolgatanga. Bolni is one of the villages that is currently benefiting from the services of the NGO. There is a representative of the NGO who lives and work with the women in Bolni. Some of the services of the NGO in Bolni village include;

1. Supporting and strengthening the capacity of farmers, especially women, to access and take control of productive resources so as to realize their right to food.

2. Reducing poverty and improving human welfare through actions that will increase poor people's access to credit, food security, education and alternative incomes.

3. Promoting the health rights and other rights of women and children amongst community members (Mabefam, 2009: Organizational profile of Grameen Ghana).

The NGO has two different groups in the village. There are the "Reflect" and "Gbakpur" (Means Discussion) groups. The women have a choice as to which group to belong to. The "Gbakpur" group conducts meetings where women discuss their problems and the ways to solve them. The NGO steps in to help with resources or

interventions to meet their needs. The “Reflect” group is where women learn about management skills, saving money, adopting healthy life practices and the importance of educating their children. The meeting times for both groups are held on different days hence the women had the opportunity to benefit from both meetings.

CHAPTER FOUR

4.0 METHODOLOGY

4.1 Research Design

To better understand the experiences on well-being for mothers in Bolni village, a qualitative research design was used. A qualitative design is a "means for exploring and understanding the meanings individuals or groups ascribe to a social or human problem" (Creswell, 2009:4). A qualitative research helps to gain an in-depth information on the experiences of participants, to collect data in their settings, analyze the data inductively and to make interpretations of the meanings of the data (Creswell, 2009). Most importantly, the phenomenon is investigated from the "perspective of the communities and individuals affected" (Green & Thorogood, 2009:6).

The concept of well-being means different things to different people. The way the mothers in Bolni experience well-being and health may be different from those of mothers in other villages of Ghana and beyond. Using a qualitative research design enabled the researcher to study the mothers in their natural setting and to identify the issues of stressors and resistance resources that emerged during the study. The flexibility of this design allowed the researcher to use methods like observation which enhanced the interpretation of the data and provided a rich description of the context (Study Area).

4.2 Strategy of Inquiry

The phenomenological approach in qualitative research was used in this study. According to Patton, it is "…one that focused on descriptions of what people experience and how it is that they experience what they experience. One can employ a general phenomenological perspective to elucidate the importance of using methods that capture people's experience of the world without conducting a phenomenological study that focuses on the essence of shared experience" (1990:71). This approach "identifies the essence of human experiences about a phenomenon as described by the participants" (Creswell, 2009:13). By this approach, a researcher is able to study a particular phenomenon as lived and experienced by the research participants. A

phenomenological study also involves the perspectives of the researcher who has a great interest in the phenomenon being studied. For this reason, it is criticized for being almost impossible to detach personal interpretations from the phenomenon under study, even though researcher subjectivity cannot be completely eliminated (Giorgi, 1994). It is therefore imperative for the researchers to try to be open and conscious of their personal experiences, interests and assumptions in collecting and analyzing data from a phenomenological study (Finlay, 2008).

For this study, the researcher had to reflect on her roles and personal experiences so as to limit their influence on interpreting the data. These are discussed in section 4.9. A phenomenological study usually involves a small number of participants to understand how and why things happen and how people relate to the phenomenon (Aspers, 2009). This approach was appropriate for the study as the underlying purpose was to understand how stressors and resistance resources affected well-being from the lived experiences of Bolni mothers. Also, it was important to capture the processes of well-being from the accounts of these women as it could mean something different to them. A phenomenological study also involves using interviews to gather descriptions of participants lived experiences, their written or verbal reports (Giorgi and Giorgi, 2003).

One of the greatest strengths of a phenomenological study is its flexibility and adaptability of methods to "ever widening arcs of inquiry" (Garza, 2007:338). By using a phenomenological approach, the researcher had the opportunity to use individual interviews and observation to give a rich description of Bolni village. This helped to gain an in-depth knowledge in the stressors affecting the well-being of the mothers and the resources used in managing them. The description of the study area could also provide readers with a richer background for understanding the results.

4.3 Study Area

The study was conducted in Bolni, a village in the Northern Region of Ghana. A detailed overview of the village is captured under section 3.0. Bolni became a subject of interest to the researcher after hearing the story of a friend who hails from the village. This friend was one of the research assistants who helped in collecting data

for the study. Bolni village is one of the poorest in the Nanumba North District in the Northern Region. Staying in the village enabled the researcher to have personal experiences of the discomforts that were created by the challenges in the village.

4.4 Participants

For the phenomenological approach for this study, it was important to purposefully select the participants (10) with the relevant characteristics for the study in order to gain an in-depth and rich information. Inclusion criterion for the study included mothers in Bolni within the age range of 25-45 years. Since the study mainly involved mothers, it was important to select mothers for the study. Therefore women who were not mothers and did not fall within the age range were excluded from the study. Though rural women encounter a lot of challenges that could be detrimental to their well-being, these challenges are likely to be more detrimental to those with child bearing and caring responsibilities. Also, to understand how SOC plays a role in their well-being could help identify the uniqueness of women who are mothers, especially those in the poor rural areas. For these reasons, the researcher chose to focus on mothers. The term women, used in this study also refer to the main participants (mothers).

According to Slater (2003), people at the stage of 25-45 years in development are more likely to settle down within relationship and begin their own families. They are likely to give back to society through raising children, being productive at work and becoming involved in community activities. This formed the basis for selecting this particular age range (25-45) because the researcher believed that many women in Bolni at this stage may have experienced motherhood and could be involved in community activities and other productive roles. These are also some of the characteristics that were considered as key for the participants in the study. There was also a wish to capture the views of other key informants who possessed adequate information on the health and well-being of mothers in Bolni. In this case, a staff of Grameen Ghana (NGO) who works with the village served this purpose.

4.5 Sampling Design and Recruiting Participants

The sampling design used for this study was purposive. Generally, a lot of qualitative researches have purposive aims, hence interviewees who will generate appropriate and useful data are selected (Green & Thorogood, 2009). It is also based on the fact that participants possess characteristics, roles, opinions, knowledge, ideas or experiences that are particularly relevant to the study (Creswell, 2009). Using a purposive sampling design enabled the researcher to explain the study, its purpose and inclusion criteria to the gatekeepers. The gatekeepers were a worker of Grameen Ghana who has been working with Bolni women for many years and one of the research assistants who hails from the village. By this, the gatekeepers were guided by the researcher to use their knowledge of the study area to choose the participants. As much as possible, those with the characteristics relevant to the study were selected. Additional characteristics like women who were vocal and had diverse characteristics (loss of children, husbands etc.) were identified. This was done without any difficulties as the participants were selected during one of the women's meetings with Grameen Ghana (NGO).

The gatekeepers later led the researcher to the houses of all the participants who were selected. Details of the study were explained to each of them and all their rights with respect to the study were made known before the interviews started. This was done with the help of one of the research assistants who interpreted from the English language to Kokomba. It is important to note that the participants selected are predominantly Christians and Traditional worshippers. Enquiries made by the researcher indicated that most of the Muslims had relocated to other regions following the conflict. The rest of the Muslims are the Fulanis who are considered as migrants, and not part of the main occupants in Bolni village. The participants were given pseudonyms coined from the first 10 letters of Salutogenesis, the theoretical framework used in this study.

4.6 Sample Size

A total of 10 participants were involved in this study. These included 10 mothers between the ages of 24-45 years. Deciding on this sample size was based on the

rational that samples for qualitative studies are mostly smaller and more data does not necessarily generate more information. Qualitative studies are more concerned with meaning than making generalized hypothesis statements (Crouch & McKenzie, 2006).

Also, this study is time bound. Analysis for qualitative researches is usually labour intensive. A large sample size could be time consuming and prolong the analysis, thereby falling behind the given duration for the study. Bolni village has a small population size (about 250 people). A large sample size could lead to repetitive data from the participants (Crouch & McKenzie, 2006; Mason, 2010).

Table 1: Overview of the participants

Pseudonyms	Age	No. of Children	Occupation	Education	Religion	Marital Status
1.Samba	25	5	Farmer	Nil	Christian	Married
2.Alafia	30	8	Farmer	Junior High	Christian	Married
3.Lulu	45	9	Priestess	Nil	Traditionalist	Married
4.Uk	32	5	Farmer	Nil	Traditionalist	Widow
5.Tala	30	7	Farmer	Nil	Traditionalist	Married
6.Osoro	35	8	Farmer	Nil	Christian	Married
7.Gaba	31	6	Farmer	Nil	Traditionalist	Married
8.Ebere	33	7	Farmer	Nil	Traditionalist	Married
9.Nene	28	6	Farmer	Nil	Christian	Married
10.Eke	30	8	Farmer	Nil	Christian	Widow

Source: Field Work, 2013.

4.7 Data Procedures

4.7.1 Data Collection

The researcher and the research assistants arrived in Bolni village on the 14th of July, 2013. The data collection period was from the middle of July to late August, 2013. During this whole period, the researcher stayed in the village. The methods of data collection for this study were in-depth interviews (Face-to-face) with the participants

and observation. A semi-structured interview guide was used in conducting the interviews. This allowed the researcher to freely probe the research participants for more information on particular points. The opportunity to explore other topics that emerged was easier with a semi-structured interview guide (Gibson & Brown, 2009). All the interviews were conducted in the homes of the participants. The interviews were done in the evenings during the week days. At this time, most of the women had returned from their farms and were done with their house chores. The participants chose their homes as the comfortable place to hold the interviews. The women indicated that the men mostly gathered under a big tree in the middle of the village in the evenings to chat. Hence the women felt it was more appropriate and comfortable to have the interviews at that time in the evenings. The interviews were held in the compound of their homes. With the exception of the NGO worker, the researcher had to ask permission from the husbands of some of the mothers before talking to them. This is deemed as a respectful act in Bolni. The Grameen Ghana (NGO) worker in the village was interviewed in his home, also in the village. The interview with the NGO worker was not subject to analysis proper since most of the issues he raised were already mentioned by the women.

During the interviews, the curious children would gather around to listen. Occasionally, they would laugh or giggle at the whole scene. However, the second research assistant controlled the situation. As soon as the interview begun, the children were quiet but seriously paid attention. Each of the interviews lasted for about 45 minutes. The interviews were conducted in the Kokomba language. The researcher asked the questions in English and one of the research assistants translated them into the Kokomba language for the participants. All the interviews were audio recorded. The other research assistant helped in taking notes. At the end of each interview, the data was immediately translated from Kokomba into English so as to identify areas where more clarifications were needed or issues that the researcher felt were not covered well. The researcher noted these down and asked the participants during the weekends when most of them were resting in the house. The interview with the NGO worker was done in only English as he was fluent and understood it very well.

It is interesting to know that, most of the women who were not selected for the interview felt that this was discriminatory. As a result, two group discussions were

organized for these women, though this was not planned as part of the data collection methods. The women felt happy with this arrangement. These group discussions were held in the school building where the women usually had their NGO meetings. They were done on the Saturday and Sunday of the data collection period. Each of the group discussion lasted for almost an hour and was recorded as well. The discussions reiterated most of the issues that were raised from the individual interviews with the participants. This enhanced the understanding of the phenomenon under study and also captured a broader range of ideas. However, these discussions were not subject to analysis proper.

During the times when interviews were not being held, the researcher would visit the homes of the women to observe what happened there. Sometimes, the farms were visited. The researcher took part in church activities held on Sundays and sat in meetings that Grameen Ghana held with the women. One of the participants gave the researcher a room in her house. Sometimes, the researcher woke up early to help the women perform their house chores. Doing this made the researcher to experience what daily life was like for a woman in Bolni village. By this observation, more of an insider understanding of the lives of the women in Bolni was gained.

In addition to the above, relevant academic work, literature and articles on resistance resources and well-being of women in rural areas were reviewed. This enabled the researcher to gain insights into the topic under study and to limit its scope to the needed area of inquiry, it also provided a benchmark to compare the results with other findings in similar studies (Creswell, 2009).

4.7.2 Data Management

All the recorded interviews were transcribed and saved on a personal laptop. This was secured with a password known only to the researcher. A copy of the transcribed interviews was sent into the email of the researcher as a back -up strategy in case of any challenges. The email is also secured with a password known only to the researcher. The recordings were immediately deleted after the transcriptions were done. The transcriptions have no original names of the participants but pseudonyms from the first 10 letters from Salutogenesis. The transcribed interviews were numbered and matched to each of the participants appropriately. These have been

filed and stored separately. They will be deleted after submitting the thesis in May, 2014.

Figure 3: Group discussion with the women.

Figure 4: Interview with a participant.

4.7.3 Data Analysis

Data Analysis involves "making sense out of the text and image data" (Creswell, 2009:183). The researcher inferred from Attride-Stirling's (2011) guide to thematic network analysis in qualitative research. By this, the data was transcribed and basic themes were generated and refined into organizing themes. These themes were grouped into two global themes under stressors and resistance resources. This was done in order to relate them to the research questions. Interpretations were made based on the findings in the study area and by comparing them with information reviewed from literature. The following outlines the procedure used in the data analysis.

1. The researcher read through the interviews and listened to the recordings of the transcribed data several times to ensure they were consistent and accurate. By doing this, the researcher became familiar with the data and was able to identify recurring constructs and issues raised by the participants.

2. The recurring constructs were then grouped under basic themes. For instance, all the women mentioned daily activities, little time for rest and manual labour on the

farm as being stressors. These constructs recurred throughout the interview with the women and were classified as basic themes (Table 4: Structure of Data Analysis). A table was prepared for each of the interviews and numbered per participant. The basic themes identified were attached to the quotes from each participant. This generated a total of 60 basic themes.

3. All the 60 basic themes were listed on a different sheet. This was done to easily read through them, identify and to name the underlying issues. The 60 basic themes were further refined into 8 organizing themes under stressors and 8 under resistance resources. This generated a total of 16 organizing themes. Each of the basic themes was then matched to the appropriate organizing theme. This ensured that each basic theme related to the organizing theme. For instance, the recurring constructs (daily activities, little time for rest and manual work on the farm) classified as basic themes were further refined as "work overload" under organizing theme.

4. The 16 organizing themes were further classified into stressors and resistance resources as the global themes with respect to the research questions. For instance, "Work overload" was classified as a stressor under the global theme.

5. A summary of the basic themes, organizing and the global themes was drafted in a table form (Structure of data analysis). After this, the researcher summarized all the stressors and resistance resources also in a tabulated form on a separate sheet (Table 2). This provided an explicit picture of the analytic process and laid the foundation for step six.

6. Using the two tabulated summaries of the analysis, the researcher related the findings to the research questions. Thus, the issues of stressors and resistance resources affecting the well-being of mothers in Bolni were described and elaborated upon. This helped in interpreting and relating the data to experiences in the study area and other findings in similar studies. The interpretations have been supported with the appropriate quotations.

4.8 Validity, Reliability and Transferability

4.8.1 Validity

Validity in qualitative research is captured from different points of views by several authors. According to Creswell (2009), qualitative validity means "the researcher checks for the accuracy of the findings by employing certain procedures" (p.190). Hammersley (1990) also postulates that validity is "the extent to which an account accurately represents the social phenomenon to which it refers (p.57). To this extent, the validity of an interpretation is "the truth of that interpretation" (Green & Thorogood, 2009:220). Validity in qualitative study is achieved through means like transparency, trustworthiness and triangulation. Triangulation generally means gathering data through different methods. Transparency refers to the "explicitness of the methods used, and how clearly they are outlined for the reader in research reports" (Green & Thorogood, 2009: 220).

Data for this study was collected through different methods: in-depth interviews with the participants and observation. By observation, the researcher was able to gain more of an insider understanding of the lives of the mothers in the village. The researcher also interviewed other key informants like the NGO worker in the village. Observations made and data from the NGO worker were compared to those from the interviews with the women. Though the views of key informants could not fully express the lived experiences of the participants, most of the themes expressed by the women were confirmed by the NGO worker. This helps in strengthening the findings. The researcher stayed in the village for quite a long time (Middle of July to late August) thereby, getting to know the people and their ways of life in general. To a large extent, this helped to give a thick description of the study area in order to understand the results better.

Again, the researcher tried as much as possible not to let her background influence the findings by reflecting on her roles as a researcher. A clear account of the procedures used in collecting and analysing the data has been stated throughout the methodology section. These were the strategies used to maximize the validity of this study.

4.8.2 Reliability

Reliability in qualitative study is often interpreted as the "the likelihood that a similar piece of research would elicit similar kinds of themes" (Green & Thorogood, 2009:221). This means that the approach of the researcher has to be consistent across different studies and projects (Gibbs, 2007). Reliability in qualitative studies involves steps like checking the transcripts for mistakes, comprehensive analysis of the whole data set and accounting for the roles as a researcher. In this regard, the consistency of the data is achieved when the research steps are verified through examining items such as the data reduction process and raw data (Campbell, 1996).

The strategies used to maximize the validity of this study also reflected in increasing its reliability. This stems from the fact that both validity and reliability in qualitative research requires that the "trustworthiness of a research report lies at the heart of issues conventionally discussed as validity and reliability" (Seale, 1999:266). In addition to this, Lincoln and Guba (1985) state that "since there can be no validity without reliability, a demonstration of validity is sufficient to establish reliability" (p.316). Furthermore, Patton (2002) affirms that reliability is a consequence of validity in a study. This works with regards to the researcher's skills and ability in any qualitative research (Golafshani, 2003).

The study was conducted with the help of two research assistants. One of the research assistants translated the interview questions posed by the researcher from English to Kokomba language whilst the other also took notes. This allowed the researcher and her assistants to compare and cross-check the interviews transcripts to eliminate mistakes that were committed during the transcription. However, there were some challenges encountered due to the language barrier. For instance, it was difficult getting some of the English words in Kokomba language. In some cases, there were no English words to capture exactly what the women meant in the Kokomba language. In others, a lot of English words described a particular event in Kokomba hence it was difficult picking the word that would describe the event accurately and perfectly. For these reasons, some of the responses given were not consistent with the questions posed and the issues of concern in the study. This is discussed more under limitations of the study. It would have helped a lot if it was possible to accurately

translate the interview guide into the Kokomba language, or the participants spoke and understood English fluently and the researcher understood and spoke Kokomba.

All the interviews and transcriptions were audio-recorded hence the researcher had the opportunity to always go back to them for verification purposes. The researcher reflected on her roles as stated in section 4.9. Also, the interpretations generated from the findings have been supported with evidence from the data (See appendices for structure of data analysis). The description of the study area has been captured in details under the section 3.0 as well. These give readers the opportunity to assess how reliable the interpretations of the researcher are and to judge them from the findings.

4.8.3 Transferability

Transferability is considered parallel to generalizability or external validity in quantitative studies (Crawford et al, 2000). Qualitative studies are usually specific to a smaller number of particular individuals or contexts. Hence, it is impossible to determine that the findings or conclusions will be applicable to other individuals and contexts (Shenton, 2004). Transferability refers to the degree to which the findings of a qualitative research could be generalized or transferred to other settings. It is dependent on both the researcher who gives a thick description of the study area and the reader's ability to infer that findings of the study could be similar in other contexts and how reasonable the transfer is (Lincoln & Guba, 1985; Rodon & Sese, 2008). The potential to apply the findings of the research to other settings do not necessarily require the researcher to know the settings where the findings may be applicable (Rodon & Sese, 2008). However, the researcher must give enough details of the study area so readers could assess how applicable the results could be (Klein et al, 1999).

As stated earlier, the findings and conclusion of this study might be applicable to other poor rural areas in Ghana. It could also support other similar studies done in poor rural areas in Africa. The findings highlight the concepts of stressors and resistance resources amongst the women in Bolni village. Some of these stressors and resistance resources could be similar for women in other poor rural areas in Ghana or beyond. By giving a thick description of Bolni village, readers could assess how the findings and conclusion could be transferred to other poor rural settings with similar characteristics like Bolni village. This could help make appropriate recommendations for health policies in such areas.

4.9 The Researcher's Role

Qualitative research requires inquirers to explicitly identify biases, personal background, values and culture that may shape the interpretation of the study. Subjectivity guides the researcher in the choice of the topic, methodologies and interpreting the data. Being objective as much as possible is encouraged (Creswell, 2009).

Irrespective of the fact that one of the research assistants hailed from the village, there were a few challenges. Being a Ghanaian and coming from a University outside Ghana was likely to create the impression of being rich or wealthy by the participants. It did not come as a surprise when one of the participants asked if the researcher could take her daughter away and take care of her (Implying adoption). The researcher was aware of these possibilities. To manage these, the researcher worked closely with Grameen Ghana, the NGO that was already helping the women in the village. The researcher was present at meetings organized by the NGO. This created the opportunity to talk about girl-child education and some opportunities available like international scholarships in education.

The researcher's interests in the issues of women have been shaped by personal experiences. Staying in a girl's school for three years (2002-2005) re-oriented her perceptions about women. The researcher gained more insight into the problems, weaknesses and triumphs that were shared with fellow ladies in school. For her research work at the undergraduate level, the causes and effects of female school drop outs were studied. The researcher had also stayed in a village in the northern region of Ghana for field work (three months). The experiences gained from the village helped in adapting to the Bolni life quickly. The researcher made the efforts to abide by the values in the village like learning their ways of greetings and dressing appropriately. All of these enhanced the researcher's awareness, knowledge and sensitivity to the issues of women. This helped in working and interacting with the participants in Bolni. It was not a problem staying and adjusting to the Bolni village life due to previous experiences in similar villages.

On the other hand, the researcher is a woman but not a mother. Her educational background and age could create issues of power relationship and might affect the outcome of the findings. The researcher was aware of these and reflected considerably

on them. Therefore, efforts were made to keep an open mind throughout the study. The researcher made an effort to increase the participants' understanding of their role as helpers and how important the information was for the study. This was done by explaining to them that the whole study was a learning experience for the researcher who was there to learn from their experiences. Thus, the participants took the role as the experts who got to pass on their knowledge to the researcher. The researcher also tried as much as possible to stick to her role as a learner, trying to keep an open mind free of all assumptions throughout the study. Also, the two research assistants were males and one hailed from the village. The researcher thought that this could create a bit of discomfort to the participants. However, because they knew one of the research assistants who was also present during the interview, the women indicated they would be comfortable to open up during the interview sessions. Asked on how they felt about the research assistant being a male, they responded they had known him for a long time and he was like a son to them. Consequently, it was not so difficult getting along with the women.

As much as possible, the researcher used the first two days in the village visiting and interacting with the people and learning basic greetings in Kokomba. Also, the presence of one of the research assistants who hails from Bolni helped in establishing trust quickly. This was because they trusted the research assistant as he had lived with them for long and was part of them.

4.10 Ethical Considerations

Ethics in general terms, is an enquiry into what is right or wrong. It is a disciplined attempt to justify particular values, or set of values, and to understand what kinds of conduct embody or promote these values (Bunton and Macdonald, 2004). These require considerations of "responsibilities to the research participants, professional and academic colleagues… and the wider public" (Green & Thorogood, 2009: 63). The general ethical principles captured in the standards set for the practice of health promotion were developed by Beauchamp and Childress (1995). These are the respect for autonomy (respect for the rights of individuals and their right to determine their lives), Beneficence (the commitment to do actions that are of benefits), Non-maleficence (obligations not to harm patients or clients. If there is doubt, precaution

should prevail) and Justice (the obligation to act fairly when dealing with competing claims for resources or rights).

Permission to conduct this study was sought from the Norwegian Social Science Data Services (NSD, Norway) first and later from the Ghana Health Service Ethical Review Committee. The researcher had approval from the NSD in Norway before leaving for Ghana in May, 2013. At the time the researcher began the study, there was still no response from the ethical clearance committee in Ghana. It was in early September, 2013 after the data had been collected that an email was received from the committee that the study had been approved. This was a dilemma to the researcher, however the beneficence of contributing to knowledge creation on the well-being of poor women in Northern Ghana influenced the decision to go ahead with data collection. This decision was also supported by the knowledge that bureaucratic processes may often be delayed in developing countries, and the fact that the study applied for did not hold any matters of ethical controversy that should warrant a decline from the ethical clearance committee in Ghana. The researcher acknowledges that all readers might not share this view.

Informed consent was obtained from all the participants before the interviews commenced. They were given consent forms to sign a day before the interviews started. Most of the participants could not read and understand English. The instructions, rights of the participants and information on the study were carefully explained to the participants in their local language by the research assistant. For participants who could not sign, they asked their older children in school to sign on their behalf. Others only gave a verbal consent and thought it was not necessary to sign. They were not forced to do so since a verbal consent was already given. All the participants were given copies of the informed consent form whether signed or not.

All the participants have been given pseudonyms in order to hide their identities. Therefore, they cannot be identified in the study. The interviews were transcribed in the room given to the researcher. The doors were locked to prevent the villagers from coming there as they were noted for their constant visits. This was done in order to ensure the confidentiality of the information. Permission was also sought from the participants before pictures were taken and to use them in the study as well.

As was explained in the informed consent form to participants, they were not paid for participating. This was to ensure that the participants willingly partook in the study and not because of the money. In spite of this, most of the women wanted to participate in the study at all cost. This led to the group discussions that were not initially planned for this study. However, a token in the form of a bar of soap was given to each of the main participants as an appreciation for their time.

It was stated in the information on the study that the findings may not directly benefit the participants. It was explained to the participants that the findings will help to understand other mothers/women in situations like theirs. The findings will also support those of other studies that have been conducted in Ghana and may influence health policies for women in rural areas in general.

CHAPTER FIVE

5.0 RESULTS

5.1 Introduction to Results

This section highlights the stressors and resistance resources identified from interviews with the participants. They are further related to findings from similar studies and examined from the point of salutogenesis in the discussion section. The findings are presented below.

5.2 Stressors

The stressors identified as threatening to the well-being of Bolni women were work overload, financial difficulties, negative traditions, disempowerment, motherhood, climate changes, health problems and absence of basic amenities.

5.2.1 Work Overload

This reflected in the activities the women had to perform each day. All 10 women confirmed that living in the village was simply a struggle. They had a lot of activities to do each day. They were overburdened with unending activities that they carried out daily. The activities were repeated each day (cyclical). These included fetching water, preparing breakfast and supper, weeding, planting, and harvesting. The activities on the farms were performed without any machine (Manual labour).

> "Life is full of ups and downs in this village. It feels like a curse to be a woman here. I go to the farm, do all the house chores, go to the market, harvesting and planting. It is not easy my sister." Samba.

> "I have to ensure that everyone is ok in the house. I will fetch water and prepare my husband's bath. I will prepare breakfast and supper. Sometimes, I just have to leave some of the chores and continue the next day." Alafia.

The work overload gave the women less time to rest accounting for most of the health problems they complained of. They felt unhappy that their husbands did not assist them in the house chores.

"I work all the time without rest not because I do not want to but I simply cannot." Nene.

"As a woman, I can say I work throughout the day and there is no specific time for resting. My husband will not assist me because it is a shame to see men doing house chores here." Uk.

"When I am asleep, as soon as the cock crows I have to wake up to do my daily chores otherwise I will not be able to finish." Tala.

Issues of pregnancy and delivery did not warrant a rest period for women in Bolni. They were still expected to perform their house chores to the fullest as it was their responsibility to do so. In support to this, the NGO worker in the village reiterated it was the challenges the women faced in their daily living that drew the attention of the NGO to them.

"I am a nursing mother but I still have to wake up and do what I must do as a wife. I fetch water, go to the market, cook, go to the farm and even harvest shea nuts. I hardly rest in a day". Alafia.

Figure 5: Bolni women from the farm. **Figure 6**: A mother preparing supper.

5.2.2 Financial Difficulty

All 10 women agreed that being financially handicapped was a major problem to them. They were not able to make enough sales from selling their farm products in the

market. For most of them, the only source of income was the sales they made from their farm produce. A few touched on not having any means of transporting their farm produce to areas like Tamale or Accra to sell to make huge money. Their husbands were not on regular income. As a result, the wives were left with the burden of ensuring the survival of the family. The widows in particular had extreme difficulties. With the absence of their husbands, they were left with the sole responsibility of financially supporting the family.

> "Everyone who wears nice clothes and shoes is respected in this area. I do not have money to buy all these things. When I see my fellow friends who are able to buy these things, I feel ashamed and worried." Ebere.

> "They say poverty is a curse and as you can see yourself, this is true in this village. I cannot even buy clothes to cover my children since my husband died. I look at them and feel so bad and sad." Uk.

> "As women, we also have needs like the others in the towns. It is just difficult for us. We work so hard but still do not make enough like we should to meet all our needs." Alafia.

Financial difficulty caused the women to worry and think of how to generate money. This made most of them cry a lot as they stood by the point that money was important for their survival.

> "I do not have enough money. It is difficult to support my children. Whenever my husband does not have money, it becomes worse and I think a-a-a (a-a-a indicating how prolonged the thinking becomes) and I lose weight." Ebere.

> "I get so worried when I have no money to give to my children what they want. I wonder if they will grow up to take care of me." Gaba.

5.2.3 Negative Traditions

These were traditions described by almost all the women as having a negative effect on their health. These reflected in practices that forbade women from exercising any

form of authority and living a free life without fear. Such concerns raised by the women are as follows:

Choice in selecting a spouse: The choice of life partner in Bolni is part of the village's cultural values. The women were given out to spouses chosen by their families. The marriage was prearranged without the knowledge of the wives-to-be. The women shared different thoughts on this. Most of the women believed they could have found better husbands than the ones they were presently married to if they did the selection themselves.

> "I would like to choose a man for myself. My family arranged an old man for me as a husband. It was difficult living with him. He got sick and died three years ago. Now I am the only one taking care of the children." Uk.

> "I do not like the family arrangement thing. I wanted to go to school like my friends in Tamale did but I had to end at Junior Secondary School to marry my husband since he was helping my family. I was not happy but I could not say no." Alafia.

Contrary to the above, a few of the women felt the elders were known for their wisdom and fore knowledge hence it was appropriate for them to select the spouses. Most of them had prearranged marriages and insisted their families made the right choice on their behalf.

> "I will allow my family to choose a husband for me. This saves a lot of time and to avoid troubles with the family. Besides, the old people know best and who am I to challenge them" Samba.

> "Getting a husband is very difficult these days. Some people use "juju" (Charms) to get husbands. The most important thing is that I have my own whether it is by family arrangement or not." Ebere.

Taboos: These are practices forbidden by a religious or social customs. From the interviews, the researcher felt the women had no problems with the existence of taboos but rather with the way the taboos were associated mostly with women. Almost all the women agreed these taboos ostracized them, lowered their self-esteem and it caused them to worry. Some of the taboos forbade women in their menses to

visit the stream and to cook. Such a woman during the entire period was isolated from family members and public events. She was to use a different bowl for eating and cup for drinking. She cooked separately and even outside the house sometimes. Also, a woman who lost her husband was required to stay indoors for a few weeks, to cut off her hair and wear all white after the burial. Breaching any of these taboos bore grave consequences (Sicknesses, curse, death) from ancestors or gods of the lands. Punishments also took the forms of paying fines and offering animals to the gods in atonement of crimes committed.

> "I am very careful not to do anything to make the gods angry or for the elders to charge me. I am scared of this. Some people have gotten strange sicknesses because of disobedience" Nene.

> "These are some of the things we cannot do anything about. God created us this way but they do not accept it. I feel very bad and shy because everybody will know you are doing "mameeri" (menstruating) because of how you are treated" Tala.

["Mameeri" means "I don't touch". Thus the woman is considered filthy at this time and is not allowed to touch anything.]

> "It was a bad time for me when my husband died. I could not work because I was not allowed to go out. I did not have money to even feed my children. They had to go to their uncle's house. I was very lonely with no one to talk to. At that time, I even wished to have died to be with my husband too." Eke.

One of the women, a priestess in the village felt otherwise. She was of the view that the taboos were required of her from the gods and she was satisfied with that. In return for her obedience, she was protected, favoured and blessed by the gods. The researcher felt this assertion may be due to her role as a priestess in mediating between the gods and the people.

> "I am the priestess here. I give messages from the gods to the elders and people are always coming here for consultation. There are things the gods want me to do so I can keep hearing from them. If I do not do that, I can no longer talk to them and their anger will be on me. I do not have any problem

> with that at all… it is for my own good and I do not want to lose my position as the priestess of this land." Lulu.

The researcher asked if the men were prohibited from doing anything. The women felt those taboos did not have serious consequences as those that pertained to them. For instance, men were not allowed in the kitchen. Doing this means that the man likes food. Men were not to eat some fruits (a particular type of melon) as this would make their heads softer, so they could easily break with a knock.

Second Wives: Bolni is a polygamous society and men were allowed to marry more than a wife. Different opinions were expressed by the women on the issue of second wives. Most of them stated this had positive benefits and a few thought it brought problems to them. Giving way to second wives brought a lot of problems to the women. Most of the second wives came into their homes with pride, negative behaviours and disrespectful attitudes. As a result, there was never peace in the house.

> "Chai, some of these women who come as second wives are bad spirits in disguise. They think they are more beautiful and younger than you so they do not respect anything. I do not want to have anything to do with them." Alafia.

[Chai pronounced "kayi" is a local term in Kokomba used to express great dislike for something.]

> "These second wives do not respect at all. They only come to bring troubles between you and your husband. I was not talking to the junior wife until Magajia (Referring to head of village women) settled the quarrel between us." Osoro.

> "I do not want my husband to bring in a second wife. Once he does that, it means I have failed in performing my duties as a wife. I never want this to happen to me at all." Samba.

The women complained that this behaviour has given them names like "Ulakpidaan" (Quarrelsome person) in the village. They felt unhappy as quarrelsome persons were disliked in the village.

The rest of the women felt happy when their husbands married second wives. This shot their positions higher as they got more respect in the homes and the village as a whole. Being a first wife becomes a prestigious position to hold as they served as "coaches" to the junior wives (second wives). The second wives were obliged to respect and run errands for them. Sharing house chores reduced their work overload and gave the women more time to rest.

> "It will not bother me if my husband gets a second wife. There is a lot of work on the farm…this woman will come and help and this will reduce the burden on me" Gaba.

> "I feel very privileged to be the senior (first) wife. My husband's junior (second) wife respects me and serves me accordingly. I am very happy. Yes I am because I do not have to do all the house chores. At least, I have someone to share them with" Tala

> "Becoming the senior wife is a very good thing. I feel lonely most of the times but I can talk and share my problems with the second wife. Because I am the senior wife, I get to represent the family at very important clan meetings. This is an honour. Not everybody gets this" Nene.

5.2.4 Disempowerment

The women in Bolni had limited control over issues that affected them or their households. Almost all the women agreed that they were prevented from taking part in family decisions and community meetings. The women had to seek consent from their husbands before making major decisions on their health, child birth and finances. Thus, their husbands wielded much authority and all final outcomes from decisions rested with them.

> "I do not understand why my husband thinks my suggestions do not make sense. I need his permission to do everything and I have to follow his orders. If I do anything without telling him, he reports me to the village head." Nene.

Consequently, most of the women felt they were not of any worth to themselves. They experienced a lower self-esteem. The widows amongst the participants were affected

the most as their husbands absence had almost made them powerless to do anything on their own. Any attempt to go against instructions of the men resulted in serious consequences such as divorce and being branded as disrespectful.

> "In this village, whatever you say as a woman is not taken at all either in your home or during public meetings. I feel so worthless if what I say is just disregarded by my husband in the house. I have to tell my husband about every money I get." Tala.

> "I think as a woman here, your worth begins and ends with child birth. That is all the men appreciate and value from you. As for me I do not waste my time to say anything because he won't listen to me." Samba.

5.2.5 Motherhood

Though being a mother is well valued in Bolni village, most of the women reported that having many children placed a lot of responsibilities on them. This was coupled with the fact that they had the sole responsibility of caring for them. They complained of not getting any assistance from their husbands in this regard. As a result, they ended up thinking and worrying over the health and entire upkeep of the children.

> "When the child gets sick, I worry a lot. When walking, I am always thinking about it and how to make the child well."Osoro.

> "It is very tiring combining house activities with taking care of a lot of children. Can you imagine doing this?" Lulu.

Others also felt they did not have the strength to control the negative behaviours of the children. Male children were the favourite of the men. A woman who was unable to have male children was often insulted and despised by the husband and in-laws. Some of the women also complained of aging which has made it difficult to work and care for the children.

> "I get so frustrated settling quarrels amongst my children because I have many. They sometimes assume I am taking sides and this makes me sad and frustrated." Eke.

"Some of the children are problematic. I have an older one who is so stubborn that the police arrested him. He is now in Tamale. I feel so much pain that I am the one who gave birth to this son." Ebere.

"I was worried when I did not have a male child. I had to see a medicine man who helped me otherwise I would have been a divorced woman by now." Tala.

"I thank God for that my son (She points to him). My husband threatened to go for another woman if I had delivered a girl I don't understand why they do that at all." Lulu.

5.2.6 Climate Changes

The problems the women had with climate changes came in two major forms. The first was the unpredictable nature of the climate. The women lamented there were times when the seasons had changed unexpectedly and affected their farm produce. Sometimes, the rains failed to show up or it did not rain as it should have. Consequently, they were not able to produce enough to feed their family and to sell in the markets. This was a source of worry to them. This was extremely difficult for them as they had no control over the changes in the seasons.

"Farming is everybody's job in this village. We depend on the rains for good harvest. Sometimes, the rains do not set in early and you end up harvesting nothing." Tala.

"Right now I do not know when to start planting my groundnuts. I do not want to go through what happened last year again. The rains did not come when we expected it. No one was able to harvest groundnut. It was very sad." Lulu.

"I depend on the seasons to make good yields to sell in Bimbilla. When that fails, I lose a lot of profit." Ebere.

The second major issue raised by the women was on extreme weather conditions. Almost all the women were grieved over the fact that floods had destroyed their

homes or those of their relatives and their farms. Sometimes, this kept them unproductive for months. For these reasons, any time they built their houses they used cow dung to cement the houses and the floors. This kept the mud solid and stronger to resist heavy rainfall. Also, the women affirmed that severe droughts in the area sometimes led to bush fires that destroyed their farm lands. The extreme weather conditions created some health issues for the women as well.

> "It can be very [very] hot here. Walking in this sun hurts your eyes and you get your skin so dry. When it happens this way, you cannot do anything." Eke.

> "I do not know what to wish for anymore. You know we need both the rains and the dry season but they sometimes get out of hand. Could you believe that a certain man from Makeyele town had his farm burnt because of this? You have to be careful during the dry season especially when you want to cook in the farm." Alafia.

In spite of the above challenges, the women admitted they had a lot of things to thank their environment for.

5.2.7 Health Problems

The major health problems the women complained of were headaches, bodily pains, skin problems, worrying and thinking and "Limraleen" (Fibroid). Fibroids are non-cancerous growths in the womb and usually cause no symptoms. However, they can sometimes cause heavy periods, abdominal swelling and urinary problems (MedlinePlus Encyclopaedia, 2013). Some of the women who had this problem complained of severe abdominal pains that left them unproductive for several weeks. Surprisingly, the women felt the "Limraleen" (Fibroid) disease was a natural occurrence which they had no control over. As a result, they made no effort to seek medical treatment. The researcher noted that these health problems are also linked to other stressors the women encountered. The headaches, bodily pains and skins rashes resulted from the heavy work load they did each day. Worrying and thinking came from other problems like financial difficulties and negative behaviours of husbands.

> "Walking in the sun to Bimbilla gives me severe headache and skin problems. Sometimes it becomes serious that I have to be taken to the hospital in town." Ebere.

> "When you have "Limraleen" (Fibroid), you just have to pray that the gods heal you. We do not know where that comes from, only the gods can tell. No one is wiser than them so you just wait and let the chief priest help you." Lulu.

> "As you see me, I have lost a lot of weight. This was not how I looked at first. My problems in this village are too many so I think and worry a lot. I do not feel well at all. I cry every night." Alafia.

The health problems affected other aspects of the women's lives; for example, not making enough yields on the farm and losing money from not being able to sell farm products in the main markets.

> "I do not like to fall sick at all. I lose all my strength and I have to stay home when others are in the market selling. It is a bad omen because I don't get to make money." Osoro.

> "Farming is what sustains my family. How do I work on the farm if I fall sick? People will not understand it was because you were sick, if you do not have enough harvest, they will say you are a lazy person." Samba.

5.2.8 Absence of Basic Amenities

Bolni village lacks the basic amenities needed to support livelihoods and to enhance the quality of life. The village has no electricity, clinic, a road network, no toilet facilities and proper building structures. All 10 women agreed this was a problem that negatively affected their well-being. The women had their priorities with respect to these amenities. These are described below;

Grind Mill: All the women complained bitterly of the absence of a grind mill in the village. It was a topmost need for them. This was due to the fact that they had to cover a long distance of about 12 km on foot to grind corn in Bimbilla. They were of the

view that the main meal for their families came from grinding the corn (Tuo-zaafi prepared from guinea corn). Coupled with the fact that their husbands had no motor cycles to carry them, most of them made the journey to Bimbilla almost every day on foot. The women associated this with some of the health problems they encountered. Whenever it rained, they had to walk in the muds to get there. Covering such a long distance on foot drained their energy. This had negative impacts on their health and well-being.

> "I walk to Bimbilla for many hours just to grind corn. I cannot leave my little child behind. She gets hungry and cries till we return. I cannot do anything at all because this is frustrating." Gaba.
>
> "Bimbilla is very far but I do not have any choice. If I do not go, how do I feed my husband and children? I get so tired when I return." Alafia.
>
> "How happy we will be if this village gets a grind mill. This is the main reason we walk to Bimbilla every day. Walking for that long just to grind corn! Sometimes, I feel so tired when I return from the farm but I still have to go because we have to use the corn flour for food the next day." Lulu.

Market: This was the second amenity the women complained of. Almost all the women stated this made living in Bolni very difficult for them. The women made a living from the farm produce sold in the market. For this reason again, they had to walk to Bimbilla where the big markets are located. Selling in Bimbilla was very competitive as all the other villages went there as well. As a result, they were not able to sell a lot to make sufficient money for the family. According to the women, having a market in Bolni will draw other surrounding villages to them and will cut down on their "foot trips" to Bimbilla.

> "My life here is full of struggles. There are no markets and other facilities here. I have to travel to Bimbilla everyday though I do not like it; it is the only way to make money." Tala.
>
> "There is no market here, because of this I have to walk to Bimbilla every day to sell firewood and groundnut. I get pains all over my body when I return." Samba.

Clinic: Thirdly, the absence of a clinic worried most of the women. They depended on traditional healers and herbs to treat their sicknesses. This also accounted for the problems they went through during child birth. They resorted to the traditional birth attendant whom they referred to as "the old lady". During birth complications most of the women did not survive and by the time they were carried to Bimbilla, they could not get to the hospital in time to survive. Other sicknesses like skin rashes and "Limraleen" (Fibroid) were left untreated because they had neither a clinic nor money to access health care in Bimbilla. This made them unhappy and sad. The researcher was wondering if this could be the reason the women claimed the fibroid was a natural occurrence which they had no control over.

> "There is no clinic here. When you are going to deliver, you only pray to your gods for a safe delivery." Uk.

> "During birth complications, you can easily die because we have no clinic in Bolni. Last year, I lost my sister when she was giving birth. Now I have to take care of the child." Nene.

Road Network: Bimbilla is a centre of trade and business. All the women agreed that things would have been much easier if there was a road network or a better means of transportation to Bimbilla. There are no commercial vehicles from Bolni to Bimbilla. The only option was to make pathways in the bushes to go to Bimbilla amidst the dangers of possible snake bites and other risks.

> "Sometimes when walking to Bimbilla, I hit my leg against a stone. I carry a heavy load that makes me very tired, so tired and weak that I am not able to do anything." Samba.

> "You see only two people have motor bikes in this village. You cannot ask them to take you to Bimbilla because you have to pay money to buy fuel. The only thing you can do is to walk- walk- walk." Tala.

> "Life here is not easy at all. There is no "trotro" (A term for commercial vehicle) from here to Bimbilla so will you say you will not go there? You cannot do that because you have to get money and feed the children. Bimbilla is where you can sell and get money." Nene.

Water: Until they had a borehole, the entire village used to rely on a stream as their source of drinking water. However, the women said the one borehole was not enough as other villages came to fetch water from Bolni. This made them queue for longer hours before they got water. The women were unable to complete their activities for the day on time. There was too much to be done to spend longer hours trying to get water.

> "But you have seen yourself how fetching water is like in the mornings. All the people from the other villages come here for water. We cannot sack them because we are all one people. I stopped fetching water in the morning a long time, I go very late in the evening when you will not find a lot of people." Gaba.

> "This village needs another borehole. We cannot use the stream now because it is all dried up. I spend a lot of hours just to fetch water and I am not able to complete my chores for the day." Osoro.

Poor building structures: All the houses in Bolni are built with mud and roofed with thatch. The women complained that whenever it rained heavily, some of the buildings collapsed. Most of the times, they were leakages of rain in the rooms due to the thatch roofing. After every heavy downpour, the women had a lot of work to do. They had to fetch sand for the men to rebuild the house as well as clear flooded water in the rooms and compounds. They had to go through this ordeal every season of heavy down pour. Also, the houses were not many and spacious to accommodate their large family sizes. There were about between six to eight children who shared a single room.

> "Using the cow dung to plaster our houses has helped us a lot. It has made the house stronger now. It is better now; at first when it rains we have to bring all our things out to clean the room. That is very difficult to do." Uk.

> "The problem is there is no money to build houses like the ones in the big cities. We have only two rooms. My husband sleeps in the one room and I share the other with my seven children. I only go to sleep in his room when he needs me." Ebere.

Electricity and Toilet Facilities: This seemed to be the least of the concerns the women had. Just like other villages around them, their case was not different. They had managed to live with that for many years and felt it was not a problem at all. Some of the women admitted this will save their households from paying electricity bills. The village has no toilet facilities. They used the bushes around for this purpose. Almost all the women said using the bushes as places of convenience was a form of manure to the soil. This made the land richer for cultivation of crops.

> "I heard that you have to pay money when you have light. We do not have money to pay for this. Besides, we are not the only village that has no light so it is not a problem at all. Using the lantern is very cheap." Lulu.

> "We were told that using the bush for toilet is good for the soil. That is what everyone does in this village. We have seen that it works because when you abandon the land for a long time and you start planting, the crops do very well. There are however places we are not permitted to go like the area around the stream." Eke.

> "It is not our responsibility to bring electricity here. The government people promised to do this but we have not heard anything from them. When they bring it we will be happy but when they do not, we will continue with our lives." Alafia.

5.3 Resistance Resources

The resistance resources identified in this study include supportive relationships, income-generating activities, religion, governance, motherhood, agricultural activities, good health, knowledge and skills. These resources are used by the women to manage the stressors.

5.3.1 Supportive Relationships

Almost all the women mentioned supportive relationships as a resource that helped them to manage their stressors. Having a positive relationship with their husbands seemed to be an important issue for most of the women. A positive relationship with your husband meant a successful marriage. Almost all the women indicated that this

brought contentment and joy in their lives. The more successful your marriage was, the longer it lasted. This was important to the women because their husbands were less likely to go for second wives once they lived at peace with them.

> "I am very happy that I have someone as my husband. No one will think that I have bad luck like those women who are not married." Tala.
>
> "I feel good when I am able to stay in peace with my husband. This way he does not insult me. He will be happy with me and will not think of bringing in another wife." Nene.
>
> "It is a bad omen to be sent to your family by your husband in this village. You will become an object of mockery. You have to do everything your husband likes. Though my husband is a difficult person, I am happy with myself for staying with him till now." Alafia.

Friends, neighbours and other family members are a great source of help to the women. The women laid emphasis on having peaceful relationships with other people. This strengthened the relationship and paved way for helping and supporting one another. Some of the assistance the women gained from friends and family were care during an ailments and financial assistance.

> "I have friends who are helpful to me. They visited me when I gave birth to my child and brought me presents." Samba.
>
> "Nobody likes a quarrelsome woman in this village. When you relate well with your neighbours, everyone likes and respects you. I feel satisfied when I am able to maintain peace in my house." Osoro.
>
> "Having relatives is very important. As I sit here now, two of my children are living with my aunty in Chamba. She takes very good care of them."Tala.

Also, all 10 women admitted having received enormous assistance as a result of being part of Grameen Ghana (NGO) and other women's associations outside the village. The NGO for instance, offered training on management skills, providing loans and education on healthy practices. Meetings provided a platform to interact and share experiences with other women. The women were entitled to some benefits by

belonging to associations. For example, donations were given to women who lost their husbands and gave birth.

> "I am so happy to belong to this group. They helped me raise money when my farm caught fire last year. I do not know what would have happened to me if the group had not helped me." Eke.

> "I belong to the "Gbakpur" (Means discussion) group. I meet my fellow women and laugh with them. It is a place where I forget all my problems. The NGO teaches us a lot of things. I learn with my friends how to save money and to do business." Gaba.

5.3.2 Income Generating Activities

All 10 women revealed that income generating activities were important resources that helped make life meaningful in Bolni. The women often combined two or more income-generating activities to make ends meet. Some of these activities are as follows.

Farming and Poultry: Despite their financial challenges, most of the women managed to engage in different activities to earn some money. The most popular was farming which everyone did in the village. The farm produce was what they used in feeding the family. They sold crops like corn, groundnuts and yam in the markets to get money. Farming is very important, as the women associated their success to it. Any woman who was not able to harvest enough at the end of a particular season was tagged as lazy. Farming and the money made from it gave the women some level of independence. Most of them were able to save to buy personal needs like clothes and shoes. They did not have to depend on their husbands for such items and never felt left out during occasions like funerals, festivals and naming ceremonies. This increased their respect in the village.

> "My farm yields mean everything to me. I depend on that so much that whenever I get bountiful harvest, I feel very proud because it is a great achievement for me. I am able to sell to a lot of people to get money" Uk.

"People will call you lazy if you do not harvest anything from your farm. I feel content when my yields turn out very good. I am able to sell and to feed my family." Osoro.

"When I am able to take care of myself, dressing well and not borrowing, I am much respected. This is how it is in this village." Nene.

"When I am able to buy all the things I need I get respected for that. This is because I am on my own and do not depend on others for everything." Samba.

Special Skills: In Bolni, only a few of the women were involved in hair dressing and sewing of clothes. These women went to acquire these skills in the main towns in the region. A lot of respect and honour was attached to such skills in Bolni as only a few had them. For the women with such skills, they felt very proud of themselves and had the opportunity to earn additional money. This also affected the relationships they had with their husbands in a positive way. They were tagged as hardworking. They earned a lot of respect and this made their husbands happy too.

"I feel very happy that I learnt hairdressing. People in this village and other areas come to me to do their hair. It is a tiring thing to do but I feel happy whenever I get my money for this."Tala.

"I get a lot of respect for this. I get a lot of clothes to sew during Christmas and festivals. I am able to get plenty money to buy the things I need and my husband is proud of me" Gaba.

Shea Butter Production: This was a common practice in the village. The Shea nut trees are wild plants in the Northern Region of Ghana and hence found in most of their villages. The women harvested the nuts and dried them for Shea butter production. They sold the Shea butter in Bimbilla market for money. Most importantly, the Shea butter served as cooking oil for the women. They did not have to spend money in buying oil for cooking.

"Selling the farm yields alone is not enough to get you money you need. This Shea butter has helped me a lot. I do my savings from the money I get when I sell Shea butter. I use it when I am in need." Uk.

"The Shea butter business is very good especially in the dry seasons. A lot of people come here to buy and take them to Tamale and Accra. I always harvest Shea nut and store them for the dry season." Lulu.

5.3.3 Religion

This seemed to be the most valuable resource in the village for the women. Although all the women came from different religious background, religion was one of the factors that kept them happy. Somehow, religion had a way of connecting to the inner feelings and emotions of the women. During religious activities, the women met to sing and dance. Whenever they felt discouraged or sad, the word of God came to calm and comfort them. The women stated their fears were alleviated and their hope increased. They derived joy from knowing that a higher spiritual authority watched over them and controlled their destinies.

"Church makes me happy. When I am worried and sad, I go to church and hear the word of God to calm me down." Osoro.

"When I have a bad idea (implying evil thoughts), the word of God changes my mind." Samba.

"Whenever Sunday is approaching, I get excited. Church is where I laugh, sing and dance. I meet my friends and we can talk. Sometimes I use church as an excuse to take a break from my numerous chores in the house." Alafia.

The Traditionalists had shrines located outside their homes and at special places. They carried their problems to the gods and made sacrifices as such. This caused the gods to intervene. Their involvement in religious activities and faith in their God/gods brought them luck and success.

"Offering prayers and sacrifices to the gods bring much joy to me. I know that I have someone behind me all the time." Uk.

"My gods are good to me. Sometimes, I will plant corn and the rains will not come early but I get a lot of harvest." Tala.

Figure 7: The shrine of a participant.

Figure 8: Some women at church.

They sometimes gave spiritual explanations to the bad and good things that happened to them. When their challenges got tougher, they believed there were spiritual reasons for them. This gave them hope, patience and endurance to cope as they sought spiritual assistance.

> "Everyone knows I am a lucky woman in this village. The gods are on my side so I always get plenty of harvest. Whenever something bad happens to me, I consult the gods and they tell me what to do so I do not complain at all." Lulu.

> "We are taught we will go through a lot of problems in life but God will help us go through them. So when I am having problems in the house or with people, I only pray and wait on God to help me." Eke.

5.3.4 Governance

Most of the women agreed that holding certain positions as a woman in Bolni brought respect and increased one's social position. Though the women did not hold major positions in the village, performing leadership roles during religious and NGO

activities boosted their confidence. Those women could openly express their opinions during such activities. Roles like being the head of women's associations, music leaders and chief priestesses were highly recognized in the village.

> "I love attending Grameen Ghana meetings here. That is the only place where I get the chance to freely talk." Eke.

> "As the chief priestess for the village, I hold a lot of respect. The village head consults me when there are problems in the village. A lot of the women come to me for help. I am the only one permitted to talk during community meetings." Lulu.

> "The men do not like attending church. Though it is a very bad thing, we the women feel happy because we get to do a lot of things like singing. Some of us are responsible for keeping the church money and organizing meetings." Alafia.

The researcher had the opportunity to witness some of the meetings the NGO organized with the women. During such meetings, some of the women led discussions and every woman participated in doing this. The women were in control of identifying problems in their environment and finding solutions to them. This reflects health promotion's core principle of empowerment.

Due to the low educational background of the women, the community map was drawn using symbol which were named in their local language (Kokomba). Each of the symbols represented a resource that the community had. This was supervised by a worker from Grameen Ghana. The end result was a simple but comprehensive community map done by the women themselves.

Another aspect where women had the opportunity to assert power and authority was their position as first wives. A few of them saw this as an opportunity to exercise authority and command respect from the second wives. The first wives were responsible for running the homes and commanded a lot of respect.

> "It is the duty of the second wife to learn from me. I came here first and I know a lot about this household than her. I feel happy to teach her and she respects me for that. She knows it is for her own good." Ebere.

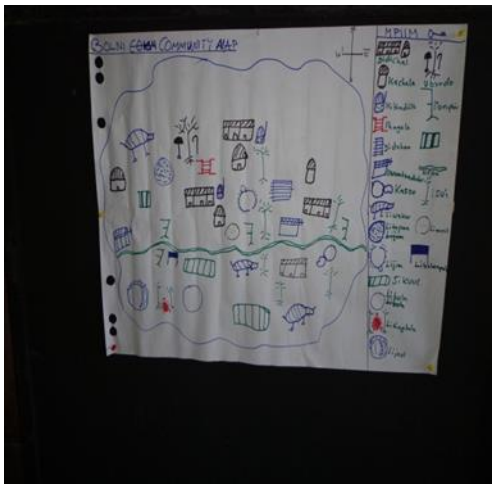

Figure 9: Community map drawn by the women. **Figure 10**: NGO meeting with women.

5.3.5 Motherhood

In spite of motherhood being seen as a stressor, all 10 women felt it was also a status they enjoyed and brought them happiness. A woman who had children was well respected in the village. Such a woman escaped the mockery of barrenness and the risk of being thrown out of marriage. This achievement solidified their roles as wives and brought joy in their marital homes.

> "No one values a woman who does not bear children. How will your husband be happy if you do not give him children? Being a mother just makes me happy." Nene.

> "I am always overjoyed having children. I feel very proud and happy when people point to me as a mother." Gaba.

Also the women admitted getting help from the children as they helped in running errands for them. They were hopeful that their children will grow up to take care of them in future.

> "Looking at my children gladdens my soul. I know that someday when I am old, my children will take care of me." Eke.

"These children misbehave at times but they will help us in the house and on the farms. At times I wonder how I could have coped without my children around." Samba.

5.3.6 Agricultural Activities

All 10 women mentioned that agricultural activities had impacted their well-being in many positive ways. There were certain lands earmarked for farming in the village because of their fertile nature. They depended on farming to feed their families and to generate money. There were a lot of plants that served as medicine for the people in treating ailments like headaches, stomach aches and snake bites. The women felt thankful for this as they had no health facilities in the village. For instance, the Shea nut trees produced nuts used in preparing Shea butter for treating dried skin and cracked lips during the dry seasons.

"I have been staying in this village for many years now and I tell you there are a lot of herbs here. But people even come here because of this. When you have headache, you just boil some of the herbs and you will be fine by the next day."Uk.

"These leaves are very good. My entire family uses that when we fall sick. It works all the time. That is why I prefer the herbs to buying those medicines from the stores." Nene.

"The Shea nut trees are all over. We do not grow them but we benefit from them a lot. We use it as pomade and oil for food." Osoro.

The village is blessed with a lot of grass and plants making it conducive for rearing animals like cattle and goats. Most importantly, their environment provided some sort of beauty and relaxation for them. They had a lot of bamboo benches fixed under the trees where they relaxed and met to chat with friends.

"This place is where we all rest after a hard day's work. Though, it is the men who sit at the place often, I feel happy to see my children playing freely outside." Tala.

"Some of the people here sleep under those trees. You get fresh air and the air blows away the mosquitoes. Some of the young people sleep there." Samba.

Figure 11: A bamboo bench used for relaxation in the village.

5.3.7 Good health

Contrary to health problems, good health was valued amongst the women just like for most people. A lot of factors combined to mean good health for the women in Bolni. The ability to work to care for the family, not experiencing any sicknesses, being at peace with all people and generally being a happy person strongly indicated well-being for the women. All 10 women confirmed they felt happy to wake up in good health with all the strength to go about their chores. Others asserted they never allowed sickness to pin them down. They continued to work as much as they could even when they did not feel well.

"Oh I am always happy when I wake up feeling strong. Sickness is not good thing. When I am healthy, I can take care of my children and work hard." Eke.

"Some time ago, a woman slept and never woke up in the next village. Ever since that time, I have always valued waking up strong and to see my friends and family in good health too." Tala.

Most of the women attributed their good health to spiritual forces. They saw their gods/God as the giver of good health.

> "Being healthy is a blessing from God. Some people get sick and they die so how will I not be happy when I do not get sick. Sickness is not a good thing. It is a curse that should be prevented at all cost." Osoro.

> "I always offer sacrifices to my gods for good health. When I wake up strong and healthy, I feel very happy. This means I can go about my business without any pains." Gaba.

5.3.8 Knowledge and Skills

The women in Bolni village acquired knowledge and skills in an informal way. Almost all the participants except for one who went to school from the primary to Junior Secondary level have never had any formal education. Through interaction with community members and participating in cultural activities, the women learned about the history of their environment, values and ways of living. The ability to perform functions such as learning how to be a good wife, speaking in public, resolving conflicts, cooking and taking care of children were learned from elderly women who were deemed as wise. Some of these roles were learnt from childhood. Women who could not perform any of these functions were seen as lazy and did not have a proper upbringing. Therefore, executing your roles as a woman commanded a lot of respect and admiration in the village.

> "In this village, we are taught how to cook as small girls. A woman who does not know how to cook will not get a husband. You must have a good character and respect to be happy in this village." Tala.

> "I am the "magajia" of this village and I have a lot of respect here. When the women have problems, they come to me and I teach them how to deal with their problems. I am happy that I am able to help them this way." Lulu.

["Magajia" is a name given to the head of all the women in Bolni. The title is only conferred on a woman who is considered old, wise and experienced in life.]

The women also received training and skills from the NGO (Grameen Ghana). They were taught how to save, manage their businesses, healthy living practices and the importance of educating their children.

> "When my husband died, it was very difficult to take care of my children but since Grameen Ghana came, I have learned how to save from my money every week. At the end of the month, the money becomes a lot. I feel happy when I see this." Uk.

Table 2: Summary of Stressors and Resistance Resources

STRESSORS	**RESISTANCE RESOURCES**
1. Work Overload	1. Supportive Relationships.
2. Financial Difficulties	2. Income Generating Activities.
3. Negative Traditions.	3. Religion.
4. Disempowerment.	4. Governance.
5. Motherhood.	5. Motherhood.
6. Climate Changes.	6. Agricultural Activities.
7. Health Problems.	7. Good Health.
8. Absence Of Basic Amenities.	8. Knowledge and Skills.

Source: Data Analysis, 2013.

Table 3: Number of Women who confirmed the Stressors and Resistance Resources

Stressors	**No. of women who did.**	**No. of women who did not.**	**Resistance Resources**	**No. of women who did.**	**No. of women who did not.**
Work Overload	10	0	Supportive Relationships	8	2
Financial Difficulties.	10	0	Income Generating Activities	10	0
Negative Traditions	9	1	Religion	10	0
Disempowerment	9	1	Governance	6	4
Motherhood	7	3	Motherhood.	10	0
Climate Changes	8	2	Agricultural Activities.	10	0
Health Problems	10	0	Good Health.	10	0
Absence of Basic Amenities.	10	0	Knowledge and Skills	8	2

Source: Data Analysis, 2013.

CHAPTER SIX

6.0 DISCUSSION

6.1 Introduction to Discussion

The researcher discusses the findings in relation to the theory of salutogenesis and the literature review. The first section covers the discussion of the stressors and resistance resources in relation to the literature review. The researcher's reflections with respect to some of the major principles in Health Promotion are also captured. The second section relates the findings to the theory of salutogenesis. This helps in understanding the well-being of the women from the salutogenic point of view and how the variables in the theory work in the lives of the women.

6.2 Discussion of Stressors

6.2.1 Work Overload

A day in the life of a Bolni woman is full of workload in the house, the farm and with little or no support from the husband. This also led to most of the health problems (also a stressor) the women had. The women combine their work load with the roles of **motherhood**. The work overload and care for larger family sizes result in tiredness, less time for rest, worrying and thinking. The findings confirm those of other studies done in similar rural areas within and outside Ghana. For instance, this supports Avotri & Walters (2001) study in the Volta Region of Ghana on Ghanaian women talking about their health and their relationship with men. The study revealed that the women were engaged in heavy work load and had little control over their work. The women did all the domestic chores and this affected their health negatively as they resorted to "thinking too much. Studies in other rural areas of African showed that engaging in longer hours of hard labour like farming and stone cracking and work overload affected the health of women in a negative way (Andvik, 2010; Kanyeka, 2010: Bull, 2009).

Also, gender roles assigned to women constrained them and limited their control over their lives and their accessibility to resources (Avotri & Walters, 2001). This is consistent with findings in Bolni. Perhaps the reason for the low educational background and development in the lives of Bolni women could be due to the

enormous time allocated to domestic chores. This is inferred from the FAO Report in 2012 on rural employment in Ghana. It showed that the women had no time to develop their capacities through skills, development and education due to the time allocated to domestic chores. The women are unable to make major decisions about their health on their own. This creates the problem of **disempowerment**; one of the stressors identified in the study.

6.2.2 Financial Difficulty

Studies have indicated that there is a relationship between wealth and subjective well-being (Dierner & Biswas-Diener, 2002). Financial difficulty is seen as one of the major factors that negatively affect the well-being/happiness of the women in Bolni. The findings reveal that the women do not have enough financial resources to afford their basic needs for survival. Not being able to secure enough money for their families' upkeep is a great source of worry to the women. Similar studies have shown that women in such rural areas work for longer hours, exploring different income-generating activities to make a living (Andvik, 2010; Bull et al., 2013; Kanyeka, 2010). This supports Avotri and Walters study (1999) on women's health in the Volta Region of Ghana. The study revealed that finding ways of earning money was very crucial for the women. Thus, the inability to secure money for the family's upkeep was a great source of worry to them.

Other studies have also shown that those who place a high value on money are less satisfied with their lives than others (Compton, 2005). The case may be different in some poor rural areas like Bolni. From the findings, the women seemed to place a high value on money. The researcher got the impression that the women felt they could have a more satisfying life if they had enough money. They realize the great changes money could make in their lives. In this instance, money becomes a valuable asset in the village. This could also be due to the fact that the women find themselves in a place where money is hard to come by. This also supports the assertion made by Snyder and Lopez (2007), that there is a strong relationship between income and well-being in the poor nations.

6.2.3 Negative Traditions

This comes in the forms of taboos and other practices that determine how a woman should live in Bolni. Taboos for instance, incited some fear in the village. The women are obliged to abide by them or face severe consequences. With the men as heads of the homes, the women need the permission and approval of their husbands to make major decisions in life. Their suggestions and contributions come second to those of the men. Taboos that isolate women and make them feel like "outcasts" have negative effects on their self-esteem. Most of the women expressed they did not feel loved, included and accepted because of these taboos. As accounted by the women, during menstruation they feel rejected and worthless as no one wants to have anything to do with them. This is in sharp contrast to Linley and Joseph's assertion (2004) that self-esteem rides high when individuals feel included, accepted and loved by those important to them.

One of the Actions in Health Promotion is creating a supportive environment for people (WHO, Ottawa Charter, 1986). In the case of women in Bolni, their environment is clouded with fear from these negative traditions. The researcher believes this destabilizes what the Ottawa Charter (1986) calls as reciprocal maintenance (to take care of each other, our communities and our natural environment). The women in Bolni give a lot to their society in terms of support and daily activities but receive less in return for their efforts and hard work.

6.2.4 Disempowerment

As stated earlier, empowerment is one of the major principles to promoting health effectively. The researcher observed that a lot of factors contribute to the disempowerment of women in Bolni. Factors like their educational background, gender roles, negative traditions and the little knowledge in health problems limit their control over their lives. For instance, tradition demands that women in Bolni respect their husbands and not to questions their decisions. Thus, making decisions for the family is the sole responsibility of the man as the head of the home. The men do not share this responsibility with the women. Therefore, they are left with no power to influence the decisions that concern them and let alone, the family. Without

empowerment, promoting health in rural areas like Bolni will remain a huge challenge. Empowering women in rural areas like Bolni should be tackled from a multi-dimensional level: considering all factors in their environment. This will create long lasting interventions and promote health effectively in these areas.

6.2.5 Climate Changes

The findings show that extreme weather conditions and the unpredictable nature of the weather/seasons worry the women. Climatic changes that negatively affect agricultural activities threaten the wellbeing of the women and their dependents. Lower crop yields in a season means the women will not have enough to feed their families and to sell for money. They will not be able to afford other basic needs due to financial problems. As noted by the UN Women Watch (2012), women dedicate their income, time and decision-making to maintain nutritional security and food for their households. At the same time, they are seen as the "managers" of food supplies during economic hardship. Though the women do not have control over the climate changes, the success of agricultural activities depend on this. This is consistent with Bull et al., (2013) study on assets for well-being for women living deep poverty in Ghana, Haiti, India, the Philippines and Tanzania. The study revealed that threats from nature such as poor soil conditions, droughts, floods and crop failure made it difficult for the women to provide food for their families. This supports the fact that well-being for most rural communities depend on the existence and use of natural resources. At the same time, natural resources provided a range of threats to their well-being (Smailes et al. 2005; McIntosh et al., 2008). Thus, whilst natural capital is a means of coping in Bolni village, it is also a stressor in itself.

6.2.6 Absence of basic amenities

Amenities such as quality water and housing, electricity, health facilities, and road networks are some of the major stressors for women in the village. These are some of the basic resources emphasized by the Ottawa Charter (1986) as the fundamental conditions for health. As indicated by the OECD Indicators of Well-being (2011), the absence of these facilities do not only affect the health status of the women mentally,

but physically. For instance, the women are unable to access and afford modern health care services. As a result, many of these women lose their babies during delivery complications. Most of these women are never able to recover from this shock and almost unable to live a happy life.

As noted by Strasser (2003), the absence of basic amenities in most rural areas could also be due to most of those amenities being located in the urban areas. In Bolni for instance, the villagers have to travel to Bimbilla, the district's capital to access health care and other services. As easy as outlining these basic resources may be, the issues of accessibility and affordability in health resources and services are very critical. The researcher believes that these should be given equal attention and emphasis especially in promoting health in rural areas like Bolni village.

6.3 Discussion of Resistance Resources

6.3.1 Supportive Relationships

Being in a supportive relationship for the women in Bolni means a lot. Receiving support from husbands, organizations (NGO), family and friends help them to cope with their challenges. The women showed more appreciation in getting support from their husbands. Maintaining a positive relationship with your husband means the marriage is working. This is also closely related to the well-being and happiness of the women. This is consistent with the assertion that supportive relationship is one of the strong predictors of well-being (Csikszentmihalyi & Csikszentmihalyi, 2006; Compton, 2005). It is also consistent with the findings from studies done in other rural areas. For example, the study on assets for well-being for women living in deep poverty in Ghana, Haiti, India, the Philippines, and Tanzania (Bull et al., 2013). The findings showed that the women were happy whenever they had a supportive and quality relationship with their husbands.

Avotri and Walters (2001) made an interesting claim in their study on Ghanaian women talking about their health and relationship with men in the Volta Region. It showed that marriage for these rural women did not always make them happy. They worried their husbands would desert them or have affairs. From the findings, the

women in Bolni also emphasized a peaceful relationship with their husbands mainly for fear that they may divorce or leave them for second wives.

Contrary to the above, most studies have also shown that relationships do not always impact positively on the well-being of people (Amarel & Bolger, 2007). Thus, relationships could also be strenuous or stressful through for example, meeting extended family demands and needs. In a typical rural area like Bolni village, collective living and relations are highly valued. One is required to offer support to neighbours, friends and family. Therefore, perceiving such relationships as stressful may label people as unfriendly and selfish.

6.3.2 Income generating activities

Though not on any regular income, the women are conscious of the positive role money plays in their well-being. It is often common for the women to combine farming with other activities like Shea butter production and brewing local drinks to have multiple streams of income. This is consistent with Bull's study in 2009 on the social determinants of health in very poor rural areas. The study revealed that, though it was unlikely for people to have a regular income in poor rural areas, the women often combined several activities to create a living in whatever means possible. Having money helps the women to provide for their needs and those of their children. Being economically empowered could have a positive impact on the women in Bolni through their increased decision-making power in households, the community and their status. This also supports other similar studies in poor rural areas where income-generating was found to play a vital role in the well-being of women (Andvik, 2010; Kanyeka, 2010; Bull et al., 2013). The findings affirm that there is a relationship between income and subjective well-being in various countries (Dierner & Biswas-Diener, 2002).

6.3.3 Religion

This is one of the strong indicators of wellbeing for women in Bolni. The women see their God/gods as the controller of their lives. Problems beyond their understanding

are given spiritual explanations. This enables them to endure and persevere through such challenges. Religious activities like church services make the women happy. Spirituality as a whole shapes the sense of meaning of life for the women. This confirms the assertion that religion is connected to the positive well-being of people (Compton, 2005; Peterson & Seligman, 2004 in Snyder & Lopez, 2007). This finding also supports those from similar studies in poor rural areas of Ghana and Tanzania (for example in Kanyeka 2010; Andvik 2010; Bull et al., 2013) where women derived happiness and support from religious associations or activities.

It is obvious that religion plays an important role in fostering well-being in the lives of most people in rural areas. However, incorporating religion in the global health promotion agenda may be a bit challenging. This is due to the differences in religious beliefs, values and practices. The researcher thinks 'individuality and uniqueness" in places where religion is valued will help in health promotion interventions. Thus, each community and its religion should be seen as distinct and unique from others. When health promoters are conscious of this, interventions will be created in line with these religious beliefs. This also supports health promotion's principle of cultural sensitivity explained in section 2.3.4. This could help promote health effectively in such communities.

6.3.4 Governance

Though some of the women hold leadership roles, they are limited to associations for women. As a result, they have less power and limited control over resources. However, the women valued leading discussions and participating in activities during NGO meetings. Religious activities also gave them the opportunity to lead in for instance, singing and being care takers of the church's finances. Such activities allowed the women to express themselves freely and make suggestions on the problems that confronted them. The researcher observed that governance for women in Boni village is gendered based on some of the interesting claims by the men who interacted with the researcher. For instance, one of the men in the village claimed women were noted for beautiful voices. Hence, it was more appropriate for them to lead singing in religious activities. This largely supports the assertion by Avotri and Walter (1999) that gender roles defines responsibilities and workloads in most rural

areas. Consequently, the women behave in a manner that is directed at increasing belongingness, inclusion and acceptance into their culture (Linley & Joseph, 2004). Behaviours that are unlikely of a woman are unacceptable in the village. Enhancing the leadership of rural women and their meaningful participation in decision-making will ensure more attention is paid to meeting their needs. In this regard, local governments provide the best arena for women in most rural areas (UN Women Watch, 2012).

The Ottawa Charter (1986) postulates that unless people are able to take control of those things which determine their health, they cannot achieve their fullest health potential. This is in sharp contrast to what happens in the lives of the women in Bolni. The degree of control the women have is not significant enough to influence major decisions on their health and other aspects of their lives. The powers wielded to them do not extend to those factors that determine their health.

6.3.5 Agricultural activities

Bolni village is blessed with natural resources like good soil and vegetation. The women make use of their natural resources in a very positive way. Agricultural activities like crop production provided food for their families and income. Selling their farm products and being able to feed their families is critical for the women in Bolni. This supports other studies in poor rural areas in Ghana that finding ways of earning money is very critical for the women (Avotri &Walters, 1999, 2001; Andvick, 2010; Bull, 2009). Certain plants in the village serve as herbs and medicine for treating ailments and sicknesses. Almost all the women prefer this traditional health care to the modern ones. The absence of health facilities and the inability to afford modern health care may have influenced this decision. This could also be due to the fact that these herbs work very well for them. Most of the women insisted on using the herbs even if they should have the ability to afford the modern health care.

6.3.6 Good Health

This contributes to the happiness and well-being of the women in Bolni. This is one of the most valuable resources for the women since their whole life centres around living in good health. Falling sick will disrupts all other productive activities for a woman in Bolni village. For this reason, they are conscious of and appreciate good health. This supports the Well-being Aggregate Report (2011), that experiencing poor health caused people to become conscious of health as an element of well-being. The women in Bolni certainly appreciate and enjoy the benefits of good health. The well-being of their families also depends on them due to the responsibilities of care (**motherood**). A mother in poor health will not be able to take care of the family. As noted by Peterson (2006), good health creates exuberance and vitality.

This supports the assertion made by Figueras and McKee (2012), that People value health as it plays a very important role in increasing economic productivity. Also, similar studies conducted in other rural areas in Africa indicated the women linked their happiness to good health (Bull et al., 2010, 2013; Kanyeka 2010; Andvik, 2010; Avotri & Walters, 2001).

6.3.7 Knowledge and Skills

Most of the women in Bolni village do not have formal education, yet they have their own means of acquiring knowledge and skills in the forms of apprenticeship and oral traditions. This is consistent with the findings of Bull et al., (2013), study on assets for women (Ghana, Haiti, India, the Philippines, and Tanzania) living in deep poverty. The study showed that formal education may be scarce in rural areas but knowledge and skills are acquired in other forms like apprenticeship. By participating in cultural activities like festivals and other ceremonies, the women in Bolni learn about their environment, culture and traditions. This supports the assertion that the participation in ceremonial occasions contributed to the informational and environmental aspects of rural life (Gauntlett et al. 2000; McIntosh et al. 2008).

The above also emphasizes health promotion's principle of participation. Though the women do not participate in decision making for their families and the village, cultural activities reinforces a sense of belonging and ownership amongst the women.

Acquiring knowledge from participating in cultural activities made the women proud. This was noticeable in the way the women expressed happiness and readiness to share about their culture with the researcher. Most importantly, the women have the responsibility of passing on these cultural values unto their younger ones in the village. Effective interventions for health promotion in such areas may have to take the same means used by rural women in acquiring knowledge. For instance, health education could be done orally in their local language.

6.4 Discussion in relation to Salutogenesis

As indicated earlier in section 2.5, salutogenesis stresses the causes or factors that promote health rather than the causes of diseases. It has the preposition that the way people view their life, the ability to comprehend situations around them and use resources available to them embodies the Sense of Coherence; SOC (Eriksson, 2007).

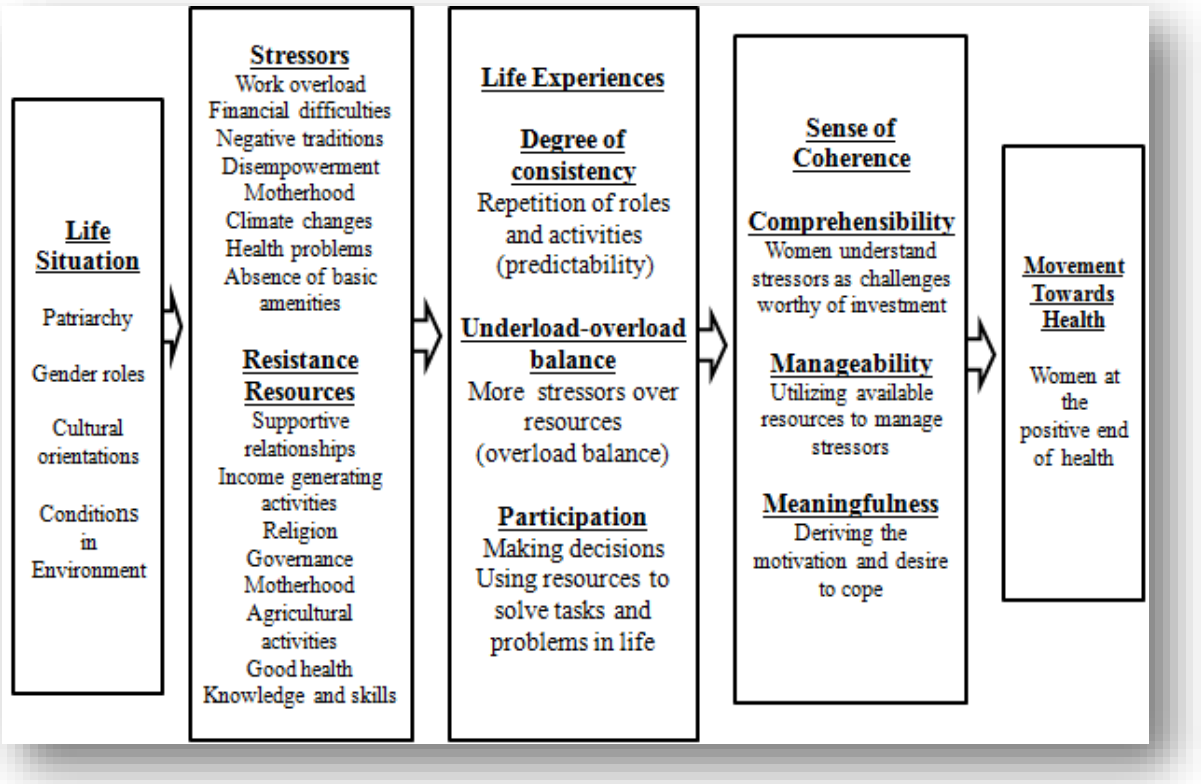

Figure 12: The salutogenic model and its application to the women in Bolni.

Source: Data Analysis, 2013**.**

In this section, the researcher contributes to the theory of salutogenesis by indicating how SOC could influence the movement of Bolni women towards positive well-being. In this regard, the life situations that generate stressors for the women are highlighted. The GRRs used in coping and how they shape their SOC towards the movement of positive health is also shown.

6.4.1 Life Situation

As shown in figure 12, the women in Bolni find themselves in life situations brought about by factors like culture, gender roles, environmental conditions and orientations. Culture and gender roles for instance have shaped the lives of the women to live in accordance with their demands. Gender roles for example, have placed a lot of work overload on the women. The work overload gives them less time to rest and has created some of the major health problems for the women. Factors like culture, negative traditions and gender roles are difficult to be controlled by the women. They have limited or no control over them; a situation that accounts for issues of disempowerment. The life situations have generated stressors which the women are exposed to. This has necessitated the need to search for resistance resources to cope with them. This is explained below.

6.4.2 Stressors and Generalized Resistance Resources

The stressors generated from the life situations for the women include amongst others work overload, motherhood, negative traditions, health problems and the absence of basic amenities. The women admitted to the fact these stressors are threatening to their well-being. The findings show that most of these stressors (e.g., negative traditions) have been in existence for a long period of time (Chronic) exposing them to long term health problems. At the same time, almost all the women are aware of the existence of resources upon which they draw their coping abilities. At least four of the GRRs namely meaningful activities, existential thoughts, contact with one's inner feelings and social relations should be present to facilitate the development of a strong SOC (Lindstrom & Eriksson, 2010). Some of the meaningful activities the women engage in are religious and income-generating activities. Getting money to care for their families and the inner feelings like peace and happiness from religious activities

are of great value to the women. Supportive social relations are also emphasized by the women. These in a way also contribute to the development of the SOC in the lives of the women. There are other resources like good health and motherhood that enabled most of the women to manage the stressors. The existence of these stressors and resistance resources shape the way the women in Bolni view their life experiences. This is explained in the following.

6.4.3 Life Experiences

These comprise the degrees of consistency, underload-overload balance and participation. They are explained below;

6.4.3.1 Degrees of Consistency: One attains some degree of consistency when the consequences of life experiences become predictable. Having been through repeated life experiences for many years, most of the women are able to tell the consequences of these experiences. It is important to note that most of their life experiences are as a result of collective factors in their environment. These experiences are less dependent on the individual choices made by the women. For instance, factors like daily living, gender roles and traditions are passed on from generation to generation. They are entrenched in their cultural beliefs. The women know what their daily living is like, they know what roles are expected of them and they live accordingly. For instance, they know what activities are to be performed in the mornings, afternoons and evenings. These experiences are repeated daily (cyclical) and make sense to most of the women. This makes life quite predictable for the women in this regard.

In spite of the above, stressors like climate changes are difficult to manage in the village. This is not a problem to only the women but the entire village. This is because the women are unable to predict the changes in the climate/seasons. Consequently, they are not able to make preparations to fully mange or control that. This remains a great source of worry to them. They see farming as a risky venture in the village. This supports Antonovsky's claim in salutogenesis that we can never control life completely. We have to live with this unpredictability whilst maintaining our trust and ability in life (Antonovsky, 1987).

6.4.3.2 Underload-Overload Balance: An underload balance results when the life experiences generate more resources over stressors. An overload balance results in more stressors over resources (Antonovsky, 1996). Though the women use the resources around them, they complain mostly of the numerous stressors they go through. This suggests that they cannot completely do away with the stressors in their environment. This supports Antonovsky's assertion that "Stressors are ubiquitous in human existence" (1979:89). Judging from the findings, the women are experiencing an overload balance (more stressors over resources). However, most of the women realize the existence of these stressors and work at using resources available to manage them. The women revealed that while the resources help in managing their stressors, they do not make long lasting changes in their lives. However, the most important aspect of this is how majority of these women are able to thrive in the midst of the numerous stressors in their lives.

6.4.3.3 Participation: As part of living a meaningful life, the women in Bolni finds the need to participate in what Antonovsky calls "socially valued decision-making" (1996:15). This means that the women draw on available resources to solve problems and tasks created by their life experiences. What matters in salutogenesis is that one has had life experiences that create a strong SOC and allows one to "reach out in any given situation, and apply the resources appropriate to that stressor" (Antonovsky, 1996:15). In the case of the women in Bolni, their life experiences seemed to have influenced their SOC in a very positive way in spite of the stressors that threaten their well-being. For example, all the women acknowledge the value of good health and know it is the appropriate resource against health problems as a stressor. To solve their financial difficulties (stressor), the women know they have to engage in income generating activities (resource). Most of the women participate in religious and social activities like church services, NGO meetings and festivals. Such activities help the women in solving some of the problems their life experiences create. For instance, they do not only receive financial support from the NGO but also, the opportunity to talk about their problems and create interventions to solve them.

However, there are also important areas in the lives of the women where they are not allowed to take part in decision-making at the household and community levels. For instance, they do not participate in economic decisions within their families. These have created absolute financial dependency on the men in the village, limiting the control the women have over their lives. This contributes to disempowerment which is detrimental to the development of a strong SOC, particularly to the element of meaningfulness.

6.4.4 Sense of Coherence (SOC)

Antonovsky defines the Sense of Coherence as

> "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli from one's internal and external environments in the course of living are structured, predictable and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges worthy of investment and engagement (Antonovsky, 1987:19).

This is made up of the components of meaningfulness, comprehensibility and manageability. The stronger people's SOC, the more likely they are to engage in health promoting activities and to move towards health (Antonovsky, 1987). These three dimensions interact with each other (Lindstrom & Eriksson, 2010). With regards to the study, it means that the women with a strong SOC will move towards health and those with a weak SOC will not. This is explained below.

6.4.4.1 Comprehensibility: This refers to the extent to which one has a dynamic feeling of confidence that stimuli from internal and external environments are structured, predictable and explicable (Antonovsky, 1987). Comprehensibility forms the cognitive component of the SOC. From the findings, the women live in a society that is already structured in terms of leadership and power. Women are not allowed to go behind their husbands or men to make any decision without their consent. Girls and women are trained to live according to the cultural and gender demands in their environment. Before a girl is born in Bolni village, their roles are predetermined. These roles are learnt and performed throughout their child hood to adulthood. Some of these roles include cooking, cleaning and caring for family. The women understand

their roles as cooks and caretakers of the home. They do these every day and know what is expected of them. Explanations are given as to why women are allowed to do or not to do certain things (Taboos). For example, the taboo that forbids women from cooking and interacting with people during menstruation has a reason. It is a time when the woman is seen as dirty and should not touch anything. By interacting with people, it means the woman will "infect" them with her filthiness. The repetition of these activities creates predictability making life more comprehensible for the women in Bolni. To a large extent, almost all the women understand the life experiences they encounter. These have generated many of the stressors which are understood, are meaningful and predictable to them. The stressors define the behaviour of women in the village; the way they are expected to talk, relate with others and conduct themselves. For example, gender roles as a stressor do not allow women to participate during household and village meetings. This understanding has enabled majority of the women to invest their energies in the activities of the NGO to manage this stressor.

6.4.4.2 Manageability: This means that potential resources are available in one's environment to manage stressors (Antonvsky, 1987). The findings show that most of the women are able to use the resources around them to manage their stressors. This is based on their understanding that the stressors are challenges worthy of their investment or energies. For example, these women find happiness in generating income from several activities despite the amount of energy involved. Though the women experience more stressors over resources, managing is not so easy for them. It can be assumed that the manageability element of SOC was under pressure. However, as the findings show, the women keep pressing on, which is an indicator that they have not given up. This ability to press on is strongly linked to the meaningfulness element of SOC explained in the next section.

6.4.4.3 Meaningfulness: This is the belief that life is meaningful and gives one a good reason for wanting to be healthy. It is also based on the premise that life's demands are challenges worthy of investment. This forms the motivational component of the SOC. Meaningfulness is deemed the most important of all the dimensions of the SOC. It is the driving force of life that enables one to search for resources to strengthen the other dimensions; comprehensibility and manageability (Lindstrom & Eriksson, 2010). Based on the findings of the study and the researcher's

experiences in the village, there is an indication that most of the women believe their lives have meanings. It is this driving force that keeps them going despite their challenges. For instance, spirituality and religion are strong factors that give meaning in life for the women. Whilst it may be rare to find women active in farm activities in most developed countries, waking up early to work in the farms is a common thing for women in Bolni. This is meaningful to them because it is through this means that they are able to feed their families. It is this belief that enables them to utilize potential resources to manage the stressors. This has given these women a strong SOC that motivates them to move towards health. Meaningfulness is also a consequence of participation in what Antonovsky calls "socially valued decision-making" (1996: 15). Taking part in keeping the family running and healthy was such a valued activity to the women. This could also be connected to the value they place on their children, family and the village as a whole. Most of the women are willing to make life better and stay healthy for the sake of their children and family.

6.4.5 Movement Towards Health

The findings indicate that there is a strong relationship between the movement of the women in Bolni towards well-being/health and the strength of their SOC. Antonovsky (1996), postulated that the strength of a person's SOC is a significant factor in facilitating the movement towards health. WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1948:100). The women in Bolni have not attained a complete or perfect physical, mental and social well-being; if that is ever possible! However, they do realize the importance of remaining healthy. As shown in the findings, most of the women are motivated to remain in good health. Being in good health is central to the daily lives of the women.

Most of the women are able to move towards well-being because of having a strong SOC. Among the specific roles that SOC plays in well-being, the women were guided to select amongst the available resources the appropriate one to manage specific stressors. Their ability to behave in accordance to the norms and values in the village and perceiving most of the stressors as ordered is as a result of having a strong SOC. It is also important to note that a few of the women may be unable to manage their life

stressors very well. In salutogenesis, these are women who have a weak sense of coherence. Hence they move towards negative well-being. Such women are negatively labelled in the village. They are seen as lazy, disrespectful and even cursed. This may also contribute to the reasons for which majority of the women are able to use available resources in managing their stressors. Perhaps they do not want to be given such negative labels in the village.

Thus, the ability for one to move towards positive well-being/health depends on how well the SOC is perceived or manipulated. The findings suggest that the women in Bolni village are an epitome of resilience. They go through stressors that could bring "tears" to their eyes yet; most of them manage to "smile". The researcher also believes that the relationship between these two (movement towards well-being and the strength of SOC) could also depend on a lot of variables such as the population being studied, the geographical location and individual strengths. Studying how this works in the lives of women in different places could generate different findings. This could throw more light on understanding the relationship between one's movement towards health and the strength of his or her SOC.

CHAPTER SEVEN

7.0 LIMITATIONS, RECOMMENDATIONS, SUMMARY AND CONCLUSION

7.1 Limitations

Due to limited resources like money and time, the study did not cover a larger population and study area. Hence, the findings cannot be generalized to other villages though, they provide an in-depth understanding into the lives of women in Bolni. Also the researcher could not get back to the respondents to probe further into some of the findings.

Another limitation has to do with the differences in language. This is also described in section 4.8.2. The researcher could not speak and understand the Kokomba language. All the participants except the NGO worker could not speak and understand the English language as well. These created some challenges with the translation which the researcher thought might have affected the participants' responses to some of the questions. There are a lot of words in the Kokomba language to express a particular feeling or situation. It was difficult to get the English word to capture exactly this feeling or situation. For example, it was challenging to translate "How will you tell or describe a successful woman in Bolni?" into English. The term successful means "uninyuun", "unikpaan" and "tinyoo" in Kokomba. There was uncertainty as to which of these words would be appropriate for successful. Later when the interviews were being translated from Kokomba into English, most of the women referred to being successful as making profits. Making profits was not exactly what the researcher expected. Responses such as the above did not reflect the aims and objectives of the study.

7.2 Recommendations for Future Research

Bolni is just one of the small villages in the Northern Region of Ghana. The qualitative research design used for the study did not permit covering more women and geographical areas. This limits the findings to Bolni village. To generalize the findings to a larger population, similar studies using quantitative methods need to be

conducted on a larger scale. This could contribute to a deeper understanding of the processes of well-being and salutogenesis in the lives of women in poor rural areas. This could guide the creation of effective health policies in those areas.

The researcher observed that the NGO (Grameen Ghana) played a significant role in fostering the well-being of women in Bolni village. These roles were not explored in detail since that was not the focus for this study. Exploring this further in future studies could draw attention to the existence of NGOs and their significance in health promotion. It could also emphasize the principle of partnership where NGOs will be directly involved in creating health interventions with the governmental and research institutions.

This section of the study reminds the researcher of a statement made by one of the men in Bolni village. He said “Why do all people who come to this place interested in the women. Do we not have problems too?” Given the enormous power and control these men have, it would not be such a bad idea after all, to study the processes of well-being and how salutogenesis works amongst men in poor rural areas of Africa. This might further inform health promotion activities in poor rural areas and promote inclusiveness in health studies.

7.3 Some Policy Implications of Findings for Health Promotion in Ghana

Achieving health and well-being requires the effort of not only individuals. It is a collective responsibility; social, economic and ecological contexts influences health (MacDonald, 1998). The role of government in promoting health cannot be overemphasized. As noted by MacDonald (1998), Health Promotion is “not apolitical rather, it is an explicitly, politically oriented activity” (p.28). “Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures…” (The Declaration of Alma Ata, 1978). A policy is defined in the New Oxford Dictionary of English as "a course or principle of action adopted or proposed by a government, party, business or individual". The health policies of government may affect its people either negatively or positively.

Whilst these implications may be applicable to many rural areas like Bolni in Ghana, they may not be the same for those in other developing countries. However, unearthing these issues could be a wakeup call for governments in most developing countries to invest in and prioritize studies on well-being in poor rural areas. This will bring forth the real and practical problems in such areas so policies could address them effectively. The study highlights major economic, social, health and cultural issues that affect the well-being of mothers in Bolni village. Some of the possible policy implications for Health Promotion in Ghana are as follows;

1. Education/Knowledge of Health: Most of the women have low educational backgrounds with little or no knowledge in health issues such as family planning. There are no modern means to information and communication (telephones, televisions and radios). They have large family sizes with inadequate resources to cater for them. This implies a high dependency ratio not only for the people in Bolni, but the government as well. Heath policies must capture efforts to promote smaller family sizes, accessibility to affordable family planning services and expanding education for girls in such rural areas. The policies should be directed at creating means of increasing awareness on health issues in such areas.

2. Disempowerment: Disempowerment for the women in Bolni is rooted in cultural values, patriarchy and gender roles. To empower women and promote health effectively in such areas, policies should incorporate more of their cultural values. Empowering the women cannot be achieved in isolation of these values hence traditional leaders, husbands and men in general should be involved.

3. Lack of Basic Amenities: The village has neither health facilities nor any of the basic amenities to improve the quality of living. If there are such facilities at all, they are located far in other developed communities in the region. Women and children requiring emergency medical services stand the risk of dying before arriving at the hospital. Health policies should cover the accessibility to health facilities in such poor rural areas. Clinics should be established within the reach of the people. Ways of creating affordable emergency transportation systems should be incorporated into the policies.

4. Financial Opportunities: Financial prospects in Bolni lie mainly in farming and forestry. However, they are not able to fetch sufficient income from them to sustain

the well-being of their families. Health policies should cover the establishment of small scale industrial activities and micro credit facilities in such areas. This will create more financial opportunities and supplement the income of the people.

5. Partnership: This is one of the core principles of Health Promotion. This is based on the premise that the interaction of multiple forces in a system produces greater results than the sum of individual effects (synergy). The responses to the needs of women in rural areas like Bolni are often initiated by NGOs, philanthropists and other private agencies. The government should form partnerships with these organizations that work in the rural areas. A combined effort could be very effective in promoting the health of women in deprived areas like Bolni.

7.4 Summary and Conclusion

The study aimed at understanding the factors that influenced the well-being mothers in Bolni village. This was based on understanding their processes of well-being and discussing the findings from the salutogenic perspective. Through data collection methods like individual interviews and observation, the stressors and resistance resources that affected their well-being were identified. The findings showed that stressors like work overload, financial difficulties, negative traditions, health problems and absence of basic amenities threatened their well-being. However, the women reached out to available resources like supportive relationships, religion, motherhood, income-generating activities and good health to manage the stressors.

Factors like work overload, financial difficulty, health problems and the absence of basic amenities were mentioned by all the women throughout the interview as having a negative impact on their well-being. Whilst others may think that amenities like health facilities, quality housing and education are more important to wellbeing, the women mentioned grind mill as their most important amenity. Providing and affording daily bread for their families depended on using the grind mill (for processing crops for food and for sale). This suggests that the ability to feed their families greatly impacted their well-being compared to other amenities.

Also, most of the stressors for women in Bolni village have their roots in cultural beliefs. For instance, work overload, negative traditions, disempowerment and gender

roles sprung from their cultural beliefs. The cultural beliefs formed the basis for most of the taboos and the hierarchical structure that gives men a lot of power in the village. These cultural beliefs created gender roles that determined the chores the women performed. Health problems like fibroids and diseases that were difficult to cure were assigned to external forces. They believed the gods were responsible for the fibroids and hence incurable. Breaking any of the taboos resulted in curses in the form of diseases or even death from the gods. That is the extent to which cultural beliefs influence well-being for women in the village. This indicates that promoting health in an area like Bolni village may work best when done closely in relation to their cultural beliefs.

Resistance resources such as religion, motherhood and being married are strong indicators of well-being and happiness for the women in the village. Women who were married and had children were more respected and honoured than those who did not. This increased a woman's status and provided an avenue to escape from being ridiculed and labelled as "evil" or "cursed". Religion played an important role in fostering well-being for the women in Bolni. The women believed higher spiritual authorities (gods/ancestors, God) were in charge of their destinies. Hence, they assigned circumstances in their lives to these authorities. This gave them the perseverance to go through their challenges even as good deeds were also seen as blessings from these authorities.

In salutogenesis, the strength of an individual's SOC is important to facilitate the movement towards well-being. The findings suggest the women have a strong SOC which facilitated their movement towards the positive end of the health ease/dis-ease continuum. In this sense it is not about health being the absence of diseases alone but the ability of the women to thrive in an environment where stressors are present. This stems from their ability to understand the stressors as challenges worthy of their energies (comprehensibility). This directs their energies towards utilizing resources available to manage the stressors (manageability) from their motivation and willingness to cope (meaningfulness) in life.

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APPENDICES

POEM DEDICATED TO WOMEN IN BOLNI VILLAGE.

"Their Smiles Behind the Tears"

1. In the North of Ghana lies a small village,
   Surrounded by nature in all of its beauty
   The trees shower fresh air to passers-by
   Birds chirp heartily as if welcoming the children for play
   The atmosphere saturated with a peaceful calm
   Bolni, a village of warm and welcoming people.

2. In all she does her family comes first
   The joy of womanhood is seen in her smile
   In the midst of scarcity, she strives to create abundance
   Bereft of her own needs
   The burdens of others she gladly shares in
   Blown by the winds of daily struggle
   She stands firmly rooted in hard work
   The Bolni woman, a symbol of strength and affection

3. With hardship woven through her day
   A family heritage is her gain
   Tilling the land to fill the barn
   Teaching her children the best she can
   Not surrounded with the glamour of life
   The joy of motherhood is her pride
   As cocks crow to greet the morning light
   She wakes to chores with sheer delight
   So the smiles behind the tears
   Brought about by resilience

STUDY PERMISSION FROM NSD

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Vår dato: 22.04.2013 Vår ref:33886 / 3 / KH Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 15.03.2013. Meldingen gjelder prosjektet:

33886	*Stressors and Resilience Resources among mothers in Bolni village: Policy implications for Health Promotion in Ghana*
Behandlingsansvarlig	*Universitetet i Bergen, ved institusjonens øverste leder*
Daglig ansvarlig	*Torill Bull*
Student	*Eunice Abbey*

Etter gjennomgang av opplysninger gitt i meldeskjemaet og øvrig dokumentasjon, finner vi at prosjektet ikke medfører meldeplikt eller konsesjonsplikt etter personopplysningslovens §§ 31 og 33.

Dersom prosjektopplegget endres i forhold til de opplysninger som ligger til grunn for vår vurdering, skal prosjektet meldes på nytt. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html.

Vedlagt følger vår begrunnelse for hvorfor prosjektet ikke er meldepliktig.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Kjersti Håvardstun

Kontaktperson: Kjersti Håvardstun tlf: 55 58 29 53
Vedlegg: Prosjektvurdering
Kopi: Eunice Abbey, Fantoft Studentboliger, P. O. Box 635, 5075, Bergen, 5075 BERGEN

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 33886

Based on the information we have received about the project, the Data Protection Official can not see that the project will entail a processing of personal data by electronic means, or an establishment of a manual personal data filing system containing sensitive personal data. The project will therefore not be subject to notification according to the Personal Data Act.

The Data Protection Official presupposes that when transcribing interviews, or when otherwise transfering data to a computer, one does not register any information that makes it possible to identify individuals, neither directly nor indirectly. All electronic processing of data in the project must be done anonymously. Anonymous information is defined as information that in no way can identify individuals in the data material, neither directly by name or social security number, indirectly through a combination of background information or a list of names referring to a reference number, or through an encryption formula and code.

No individual will be recognizable in the master thesis or other publications.

The consent form contains 10 statements. The data Protection Official strongly recommend that the letter of information and the consent form is rewritten in such way that the consent form only contains number 1 and number 10 of the statements. The other statements should be a descriptive part of the letter of information from the student. Please send us a revised letter of information and consent form to the following address: personvernombudet@nsd.uib.no

INFORMED CONSENT FORM FOR PARTICIPANTS

The following will be clearly explained into details for the participants in their local language. This would be assisted by a translator fluent in both the local (Kokomba) and English languages. A copy of this form will be drafted in the local language for participants.

TOPIC: Their smiles behind the tears: Stressors and Resistance Resources Amongst Mothers of Bolni Village in the Northern Region of Ghana.

(A Qualitative Study)

PRINCIPAL RESEARCHER: Eunice Adusei

University of Bergen, Norway. Department of health promotion and Development

SPONSORSHIP: Not Available

INFORMATION ABOUT THE STUDY

The Purpose

The general aim of the study is to understand the health and well-being of mothers in rural areas. This study seeks to identify the stressors or challenges that affect your well-being as mothers in this area. The researcher is particularly interested in the resources or factors that help you to cope with these stressors; those experiences that are positive in your lives.

Details

Ten (10) individuals will take part in this study being conducted here in Bolni village. This number includes mothers between the ages of 25-45 years and some local NGO Officials. Participating in this study involves an in-depth interview of about 1 hour with you. Interviews will be held at your home or any place of your choice here in Bolni. The researcher will be assisted by two other research assistants. Notes will be written and the interviews will be audiotaped. Findings from this study will be written in a report to be submitted to the University of Bergen as part of the researches for a master's degree. An article may be produced afterwards and published in a peer

reviewed journal. Doing this will inform health promotion policies in Ghana especially on the well-being and health of women in rural areas like Bolni.

The study involves only those who will voluntarily participate. Participants are free to withdraw at any time during the course of the interview. This is not a medical study and there are no medical risks involved.

The researcher will not identify participants by name in any reports using information from this interview. Confidentiality is assured. Pseudonyms will be used to hide the identities of participants.

The use of the records and data will be subject to standard data use policies which protect the anonymity of individuals. All recordings will be destroyed after they have been transcribed. The information will be stored in a safe place after the study for 2 years to allow for a follow up in the case of publication. By May, 2014, all the data will be anonymised. All participants will be given a consent form to append their signatures.

For questions about the study, contact Eunice Adusei on 0543094343. For research questions or problems regarding your rights as a participant, the Ethical Review Board may be contacted through (Hannah Frimpong on 0244516482) or 0302681109. Feel free to ask any questions you may have or any clarification on this study.

- Having understood the information given on this study, I volunteer to participate in the study conducted by Eunice Abbey from the University of Bergen, Norway. I understand that the study is to gather information as part of the academic work of the researcher. I will be one of the 10 people to be interviewed for this study.
- I have been given a copy of the signed consent form.

---------- ----------

My Signature Date

---------- ----------

My Printed Name Signature of Researcher

---------- (Relationship to participant if signed on participant's behalf)

Statement of the Researcher

I certify that the above individual has been given explanations on the purpose, nature, benefits and potential risks of this study. All questions raised have been answered. I have witnessed the appending of the signature above on the stated date.

---------- ----------

Signature of Researcher Date

SEMI-STRUCTURED INTERVIEW GUIDE (BOLNI MOTHERS)

SOCIO-DEMOGRAPHIC CHARACTERISTICS

• Age, Occupation, Educational Background, Religion & Marital status.

DAILY LIVING

1. How do you find living in this place?

(Watch for general perception of life in Bolni village).

2. How are the days like for you?

(Daily activities (morning-evening), leisure activities, work overload).

3. Is there anything in your environment (village) that you think is challenging/problematic/stressful?
   (Watch for issues like climate changes, availability of basic facilities, etc.)

MOTHERHOOD

1. How do you feel being a mother?

(Watch for any traces of happiness, well-being or stress).

2. How would you describe the family of a strong mother/woman?

(Children bringing happiness to mothers, how having kids could create problems in terms of age, number and sex of child).

SOCIAL POSITION

1. How will you tell/describe a successful mother/woman in Bolni?

(Characteristics (income-generating activities, skills, wisdom, social position)

2. How will you describe a strong and happy mother/woman in Bolni?
3. What do you think are the sources of happiness for this mother/woman?

(Faith/religion, social relationships, support from family and neighbours, quality of relationship & others)

4. What in your opinion is a good life a Bolni mother/woman?
   (Watch for what are needed /important to make a good life, what Bolni mothers/women dream of?)

STRESSORS

1. What do you think makes a mother/woman in Bolni tired or sick?
   (Make reference to interviewees)

2. What do you think are the health problems of mothers/women in Bolni?
3. What are some of your experiences (check illness, worrying, financial difficulties and others)
4. What do you think accounts for the illness or tiredness?
5. What do you think differentiate a strong and a happy mother/woman from a tired and ill one in Bolni? (Make reference to the fact of living and practically sharing the similar resources in the village).

RELATIONSHIP WITH HUSBANDS

1. Could you describe the husband of a happy/strong mother or woman?

(Watch for processes in choosing life partners (family/self), and how this choice influence happiness or well-being).

2. How do husbands behaviours make a mother/woman in Bolni happy/strong? (Decisions on finances, responsibility, Personal experiences or accounts from friends etc.).
3. How do husbands who respect their wives behave?
4. If your husband marries or got another, how will this affect you? (Being the first/second, In what ways is the above important: power, popularity)
5. What do you think makes this village respect mothers/women? (How do you know this? Does this make the mother/woman healthier or happier? Things that women could influence if they had the power to make decisions).
6. Is it important for a mother/woman that her husband is respected in this village? (Reasons & any bearing on well-being, what makes the village respect a husband).

SOCIAL GROUPS OR ORGANIZATIONS

1. Do you belong to any association/any help from an organization?

- How help/assistance is offered- skills, training
- How this creates happiness/well-being

Table 4: **Structure of Data Analysis**

Basic Theme	**Organizing Theme**	**Global Theme Stressor/Resistance Resource**
1.Child birth brings honour/respect 2. Children help in house chores. 3.Significance of male child 4. Future prospects of children. 5. Number of children & honour.	**1. Motherhood**	RESISTANCE RESOURCE
6. Inability to care for large number of children. 7. Priority placed on sex of child. 8. Aging and Childbirth.	**2. Motherhood**	STRESSOR
9. Special skills (Sewing & hair dressing). 10. Training & education from NGO (micro credit, management skills, importance of educating children.	**3. Knowledge and skills**	RESISTANCE RESOURCE
11. Daily Activities 12. Little time for rest. 13. Manual work on farm (manpower).	**4. Work overload**	STRESSOR
14. Ability to go about daily chores. 15. Strength for daily living. 16. Prevention of illnesses.	**5. Good health**	RESISTANCE RESOURCE
17. Worrying & Thinking. 18. Headaches & Body pains. 19. Guinea worm 20. Skin Problems. 21. Fibroid. 22. Diarrhoea.	**6. Health problems**	STRESSOR
23. Leading discussions during NGO meetings. 24. Authority as first wives. 25. Holding positions in village brings respect. 26. Leadership roles in religious activities (e.g. song and women's wing leaders). 27. Being considered as wise increases social position.	**7. Governance**	RESISTANCE RESOURCE
28. Inability to take part in decisions of the family. 29. Inability to make decisions on health, child birth and spacing.	**8. Disempowerment**	STRESSOR

30. Absolute dependence on husbands in all things.		
31. Successful Marriage. 32. Participating in social and NGO activities. 33. Care from friends, family and community. 34. Positive behaviour of husbands.	**9. Supportive relationship**	RESISTANCE RESOURCE
35. Good soil for crop cultivation. 36. Poultry farm (Doves, Ducks, and Guinea Fowls). 37. Plants/herbs as medicinal	**10. Agricultural activities**	RESISTANCE RESOURCE
38. Extreme weather conditions (Droughts, floods). 39. Changes in seasons (failure/or little rain)	**11. Climate changes**	STRESSOR
40. No grind mill. 41. No health facilities. 42. No toilet facilities. 43. No electricity. 44. No market. 45. No road network to main town (Bimbilla). 46. Poor Building structures.	**12. Absence of basic amenities**	STRESSOR
47. Crop cultivation. 48. Shea butter production. 49. Sale of Poultry (Ducks, Doves, Sheep). 50. Sewing & hair dressing for money.	**13. Income-generating activities**	RESISTANCE RESOURCE
51. Insufficient money to meet material & personal needs. 52. No financial support from husbands. 53. Inability to meet needs of children (education, clothes etc.).	**14. Financial difficulty**	STRESSOR
54. Faith & divinity brings success and luck. 55. Participating in religious activities. 56. Spiritual explanations for circumstances.	**15. Religion**	RESISTANCE RESOURCE
57. Choice of life partner. 58. Taboos 59. Negative behaviour of second wives. 60. Gender roles & patriarchy	**16. Negative traditions**	STRESSOR