Social Determinants of Health in Very Poor Ruralities

Striving and Thriving in Dire Conditions: Is It Possible? A Qualitative Study with Women in a Poor Rural District of Ghana

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Author's note

This thesis, along with the larger Social Determinants of Health in Very Poor Ruralities (SDHVPR) project, will be presented at the 20th IUHPE World Conferences on Health Promotion and Education in Geneva, Switzerland in July 2010. A number of articles based on the project have and will continue to be submitted in various academic journals following the completion of this report. Published articles include:

Bull T and Mittelmark MB. ***Living conditions and determinants of social position amongst women of child-bearing age in very poor ruralities: Qualitative exploratory studies in India, Ghana and Haiti.*** IUHPE Research Report Series, 5(1). Paris: IUHPE; 2010.

Bull T, Duah-Owusu M and Andvik C. ***"My happiest moment is when I have food in stock": Poor women in northern Ghana talking about their happiness.*** International Journal of Mental Health Promotion, 2010; in press.

All photographs included in this thesis were taken by the author and fellow researchers during the April 2009 field visit to the Bole District of Northern Ghana.

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Abstract

Women living in very poor rural regions of developing countries are among those in the world facing the largest, avoidable risk for early illness, disability and death. Yet, some women in very poor areas are healthier than other women living in the same communities. Identification of factors that protect the health of women of childbearing age is a priority in the UN Millennium Development Goals. This is challenging as previous research shows that the standard protective factors—higher income, higher education and higher occupational status—are poorly associated with health in very poor rural places. Thus there is a need for research to emphasise protective factors that do have relevance in very poor ruralities. This project is part of a larger project which analyses qualitative and quantitative data from India, the Philippines, Peru, Haiti, Ghana, Tanzania and Saskatchewan (Canada). The aim of the larger project is to identify protective factors for the health of women at childbearing age living in poor ruralities of these countries. This thesis presents findings from qualitative data collected in the Bole District of Northern Ghana.

This study implemented a case study design collecting data through focus group interviews, key informant interviews, personal observations during the field visit as well as information provided by a local nongovernmental organisation, GRID-NEA, established in and working with the women where the study took place. An open, semi-structured guide was implemented during the interviews and was modified as needed throughout the duration of the field visit in April 2009. Analysis of this research adapted the linear, hierarchical approach for qualitative data.

The results indicated existing connections between social determinants and women's health. The ability to bear children, traditional skills, education, religious beliefs and social status were strong indicators that affect the status and wellbeing of women of childbearing age. Social support from husbands was highly valued in addition to assistance from older children. Previous local customs marginalised women yet with the adaption of different religions and change in beliefs of roles for women, women's health and status have increased.

Although most women were not completely healthy women were able to sustain livelihoods to support themselves and their families. Unfortunately, the challenge lies in creating these opportunities because the women live in such dire circumstances. They have little access to existing resources in order to start on their own. Assistance from local organisations and agencies is necessary to create activities for them. It was difficult for a woman to succeed on her own, meaning social support had significant contributions to women's health and status.

Several elements within the field of health promotion emerged from the findings of this study. These include empowerment, salutogenesis as well as influences of globalisation. These intertwined and sometimes complex concepts can be recognised as effective means to promote health, even in the harshest of living conditions.

Key words: socioeconomic status; sustainable livelihoods; social determinants of health; poor ruralities; wellbeing; women

1.0 Introduction

Assessing social health determinants has been highly influenced by developed societies due to the fact that most research has been implemented in these regions. Studies using standard indicators to determine socioeconomic status have discovered that people with higher education, income and employment status are inclined to be healthier than those with lower (Bosma et al, 1998; Marmot and Wilkenson, 1999; Marmot, 2001; Chandola et al, 2003). However, in rural or agrarian/pastoral societies, development research finds this form of measurement insufficient. In rural parts of developing countries, family dynamics are typically much different than in the developed as many members may earn wages for the family through various income generating activities. There also exists less formal education, outside classroom settings, where people may gain skills that allow them to create a successful livelihood. Thus, these social indicators may very well differ from those in developed societies.

Socioeconomic status refers to a position on an economic hierarchy based upon income, education and occupation (AHNDCL, 2010). It can influence a person's lifestyle, prestige, power and control of resources. Measurement of socioeconomic status in poor ruralities is complicated by the fact that few households own the kinds of major consumer products that epidemiologists are most comfortable itemising, for example refrigerators, radios, cars and so forth (Deaton, 1997). Self reported measures of total income are unlikely to be reliable because of unwillingness to reveal such information to a stranger, in addition to countless transactions undertaken by such people make it unlikely that respondents know this kind of information. (Atkinson, 1970; Atkinson and Stiglitz, 1976; Nandy, 2008)

No longer can national health planners ignore the fact that a universal structure of measuring health statistics is inadequate across all countries. Research has been conducted around the globe to uncover more accurate measuring tools for socioeconomic status in developing countries. These tools must be adaptable to the context of each people group between and even within nations.

This has stimulated further research at the Research Centre of Health Promotion and Development (HEMIL), University of Bergen, in collaboration with the International Union of Health Promotion and Education (IUHPE) and the Department of Health of England. Led

by Prof Maurice B. Mittelmark, the research project on *Social Determinants of Health in Very Poor Ruralities* (SDHVPR) has explored various approaches to measure health determinants in survey research and in surveillance systems to be used in public health research and interventions (Bull and Mittelmark, 2010). The SDHVPR project aspires to contribute to the health equity work stimulated by the publication of the 2008 World Health Organization (WHO) Commission on the Social Determinants of Health (CSDH, 2008). This SDHVRP research project incorporated research conducted in Ghana, Haiti, India, Peru, the Philippines, Tanzania and Saskatchewan (Canada). Members of the group, ten in total, integrated qualitative and quantitative methods for the studies. Statistical data was obtained from various years of the Demographic and Health Surveys available online [www. measuredhs.com] for Ghana, Haiti, India, Peru, and the Philippines.

This thesis focuses on women of childbearing age living in extremely poor rural villages of Northern Ghana, West Africa. Questions examined the protective and enabling factors for wellbeing of women in these communities, as well as characteristics of a thriving woman. The focus was primarily on defining factors and influences of social position and status among Ghanaian women of child-bearing age in the Bole District of Northern Ghana. Qualitative data was collected during a field visit in April 2009.

Chapter 1 unfolds the background for the project with explanations of socioeconomic status and social determinants of health; pertaining to the lack of research in poor ruralities. The literature review in chapter 2 describes the origins of theoretical developments of the sustainable livelihoods framework and breaks down sections for greater comprehension. Chapter 3 further develops the case, describing the context of Ghana as well as the rural villages and women living in the Northern Region. Chapter 4 describes in detail the design of the study including strategy of inquiry, subjectivity, ethical considerations, sampling, data collection and analysis. Chapter 5 presents the findings of the study in relation to the capitals of the theoretical framework of the project, followed by chapter 6, an in-depth discussion in view of the research questions and relevant empirical research including key concepts within the field of health promotion. Also in this chapter are methodological considerations. The report concludes in chapter 7 with new areas of future research on social determinants in an effort to find proper measuring tools on health and wellbeing of people from very poor ruralities.

2.0 Review of Literature

2.1 Health Promotion

The WHO Constitution from 1946 defines health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. It goes on to describe health as the extent to which an individual or a group is able to realise aspirations and satisfy needs, and to change or cope with the environment (WHO, 1984). Health, therefore, should be viewed in a holistic manner and not just prevention or treatment; a major cause for WHO's adaption towards health promotion during the 1970's and 80's.

Health promotion is 'the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing (...) health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being' (WHO Ottawa Charter, 1986). Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasising social and personal resources as well as physical capabilities (WHO, 1984). Fundamental conditions in the Ottawa Charter (1986) not only include food, water and shelter for all persons but equity, justice and stable eco-systems.

Wellbeing is a key aspect in health promotion. Over several decades this concept of wellbeing has been explored to grasp its essential characterisation. In health promotion, it can be expressed as one's happiness and life satisfaction including positive and negative emotions and moods (Chambers, 1995; Diener et al, 1999). Wellbeing can be described as one's security, welfare and interests (Atkinson, 1970; Buhmann et al, 1988; Marmot et al, 1997). It reaches all facets of a person's life.

2.2 Social Determinants of Health

Since the commencement at the 1986 Ottawa Charter, health promotion has continually evolved, raising awareness in all regions about the importance of health in everyday lives. Goals are set by health organisations worldwide and reports published, presenting the latest findings, achievements and setting new objectives. Towards the end of 2008 the WHO Commission on Social Determinants of Health (CSDH) presented strategies to narrow in on inequities of health in and between countries. It argued that, 'inequities in health arise

because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces' (CSDH, 2008, p. 3).

There is an immense focus on bridging the divide of these health inequities between and within developing and developed societies. To get a better idea, Figure 1 illustrates the macro framework for the WHO's CSDH project. It reveals influences of social position and assets on people's health and wellbeing. Social position defined by Marmot (2003) as 'linked to the circumstances in which people live and work' (p. S17).

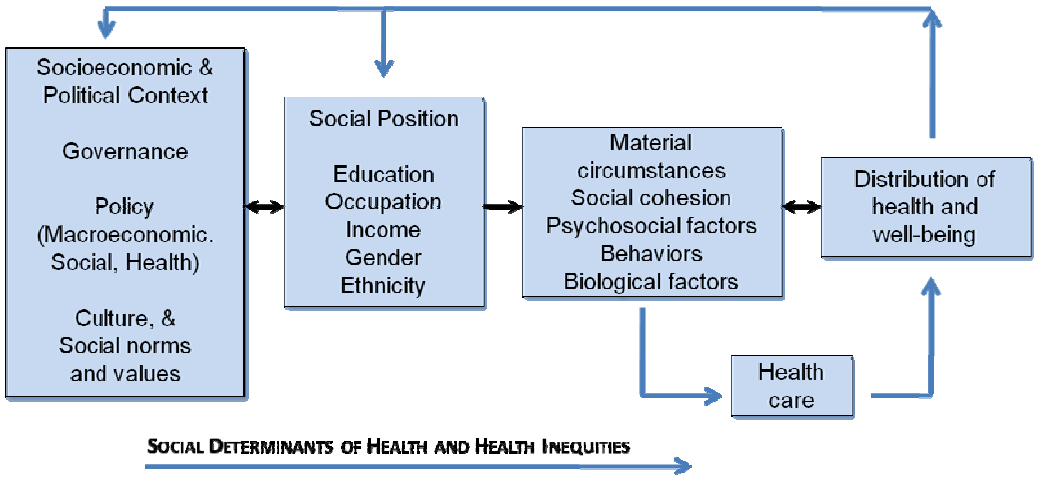


Figure 1. Adapted from Social Determinants Conceptual Framework, CSDH (2008)

The model presented in the 2008 report is the overall framework of the CSDH project. It does not, however, distinguish differences between poor urban and poor rural areas- a major element in our project on SDHVPR. The CSDH framework is not the best representation for our project on SDHVPR therefore we have incorporated another model that better supports our area of research, a sustainable livelihoods approach.

2.3 Sustainable Livelihoods Framework

A sustainable livelihoods approach depicts the complexity of livelihoods, relating for instance to households, gender, governance and farming systems, to bring together relevant concepts allowing poverty to be understood more holistically (Farrington et al, 1999). Chambers and Conway (1992) describe sustainable livelihoods as:

> "A livelihood comprises the capabilities, assets (including both material and social resources) and activities required for a means of living. A livelihood is sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities and assets both now and in the future, while not undermining the natural resource base." (p. 6).

The authors criticised many previous analyses of production, employment and income as industrial and minimalist as they do not capture the complex and diverse realities of most rural life (Chambers and Conway, 1992).

This model (Figure 2) illustrates the Sustainable Livelihoods Framework (SLF) though modified to enhance its significance within health promotion. The SLF has been utilised internationally by development agencies and researchers, including Department for International Development (DfID), CARE, Oxfam and UNDP (Carney, et al, 1999). No universal depiction of the SLF exists thus for the SDHVPR project we have adapted the one shown below.

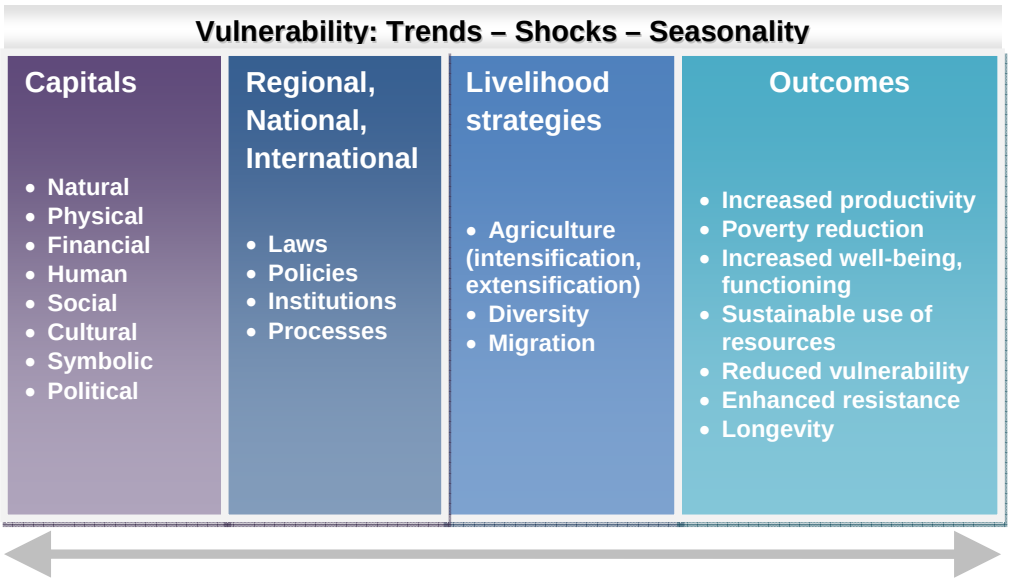


Figure 2. Adaptation by MB Mittelmark of the Sustainable Livelihoods Conceptual Framework; see Carney, et al (1999)

This framework interprets social determinants of health in various forms of capital, or resources, that a person possesses in order to manage daily living, cope with vulnerability and build capital to reduce their level of poverty. This model is a representation of the major elements in all SLFs. Some additional aspects to better fit our project consists of cultural, symbolic and political capitals. Another inclusion is longevity as an outcome, given that we

believe health can and does allow for an endured life. This project centres on health determinants and therefore longevity would be appropriate to include in lasting effects.

The vulnerability context frames the external environmental factors in which people exists- the critical trends, shocks and seasonality which people have limited or no control over (DfID, 1999). These factors include anything from population trends, economic trends, conflict, and seasonality changes of prices, production, employment opportunities, etc. Trends are more predictable and influence chosen livelihood strategies. Shocks can force people to abandon their home areas and dispose of assets as a way of coping. Seasonal shifts as mentioned above can have the greatest impact of hardships for people in developing countries. Though not always negative, the term vulnerability stresses the complex influences directly or indirectly responsible for many of these hardships. (Carney et al, 1999; Chambers and Conway, 1992; DfID, 1999)

The eight capitals listed within this framework (natural, physical, financial, human, social, cultural, symbolic and political) play an important role. They can be, at times, strongly interlinked and definitions may vary. Below are the definitions relative to the SLF within our project on SDHVPR.

Natural capital- comprises natural resource stocks like air, water, soil, etc. These can be both non-renewable like oil, coal, metal ore and renewable resources such as forests, fisheries, grasslands (Hawken, 1999).

Physical capital- includes basic infrastructure and produced goods needed to support livelihoods (DfID, 1999). These can consist of roads, shelter and buildings, water supply and sanitation, energy supplies and telecommunications.

Financial capital- includes economic sources like cash, credit/debt, savings and regular inflow of money from income generating activities. This can also include material ownership and food security. (DfID, 1999)

Human capital- is attributes of a person including skills, knowledge and ability to work; not excluding informal education, participation or training which are commonly found in poor ruralities (Becker, 1993).

Social capital- includes the social resources, formal and informal, like networks, relations, affiliations, associations and position in the family or community (Bourdieu, 1986).

Cultural capital- involves passing down knowledge from older generations to younger. Three types are defined as (1) the embodied, mental or way of thinking; (2) objectified, physical objects or possessions; (3) institutionalised, academic or training (Bourdieu, 1986).

Symbolic capital- a resource, either tangible or non-tangible, that is given recognition, value or power as defined by an individual or system in which it is valued (Bourdieu, 1986).

Political capital- includes ideas/beliefs of individual or people group's powers generated through participation in interactive political processes linking civil society to the political system (Sørensen et al, 2003).

In relation to the SLF's vulnerability context, these capitals have an effect on livelihood strategies in various ways via trends, shocks and seasonality. Refer to the results chapter for examples (p. 25).

2.4 Socioeconomic Status

There are two major interwoven components of socioeconomic status: class and position. Socioeconomic *class* refers to social groups that arise from interdependent economic, social and legal relationships among a group of people (Krieger et al, 1997). Socioeconomic *position* is a collective concept, making reference to holdings of assets, the income that these assets yield, and the consumption that such income permits (Krieger et al, 1997).Though an important cultural construct, socioeconomic class is poorly used in research (Lui et al, 2004). Problems in using social class may be associated with its poor definition in previous studies, for instance, combining social class and socioeconomic status, using objective indices such as income, education, and occupation rather than subjective measures, regarding social class as an adult experience and not focusing on classism (Lui et al, 2004).

Socioeconomic position is generally conceptualised as referring to the diverse components of economic and social wellbeing that differentiate persons of different social classes, including both resource-based and prestige-based measures (Morris et al, 2000). Wealth and income are two important dimensions of socioeconomic position. In developed countries, there is a wealth of data both on socioeconomic class and on aspects of socioeconomic position

(Krieger et al, 1997). By contrast, in developing countries, especially in rural areas, such data are far less readily available, and measurement of these determinants of health outcomes is challenging (Morris et al, 2000; Nandy, 2008).

Previous research indicates an association between social position and health in developed countries, as found in Great Britain and the United States (Marmot et al, 1997). These authors argue that mortality rises with decreasing socioeconomic status (p. 901). Statistical data verifies that social inequalities exist within these countries as studies reveal social gradients in health from one social class to another (Lynch et al, 2000; Bosma et al, 1998; Marmot and Wilkenson, 1999; Chandola et al, 2003; Stronks et al, 1997; Geyer and Peter, 2000). These investigations portray how health surveillance systems are more adequately employed in a developed country than in lower-income countries, allowing for a more realistic representation at national levels.

There are too few studies on social determinants of health within developing countries to properly assess socioeconomic inequalities for these nations (Murray and Lopez, 1996; Victora et al, 2003; Marmot, 2005). Health status is commonly reported at a national level and not always reliable due to lack of health surveillance systems in remote villages (CSDH, 2008; Marmot et al, 2008). In the few studies that have been conducted in poor ruralities, findings indicate the difference between the poorest and those better off was not the likelihood from falling ill but rather in the treatment once sick (Schellenberg et al, 2003). Schellenberg and colleagues (2003) conducted research in poor ruralities of Tanzania. They found wealthier families are inclined to have better knowledge of warning signs of diseases and how to treat them, resulting in higher recovery rates. However, this might not be the case in all poor ruralities. Research is still needed, particularly in societies where social inequity prevails or is rising (Peña et al, 2000).

2.5 Research questions

In this research, the capitals as listed in the SLF model were considered in order to understand how these social determinants—life skills, training, social position—may affect women's status and health as a means to thrive in poor ruralities, despite adversity.
This study focuses on women of childbearing age in extremely poor ruralities, specific to rural villages of Northern Ghana, West Africa. Questions examine the protective and

enabling factors for wellbeing of women in these communities, as well as characteristics of a thriving woman.

- What defines social position and status among Ghanaian women of child-bearing age residing in the Bole District of Northern Ghana?
- What factors contribute to social position and status among Ghanaian women of child-bearing age residing in the Bole District of Northern Ghana?
- What influence has social position and status on the health of Ghanaian women of child-bearing age residing in the Bole District of Northern Ghana?

3.0 The Case

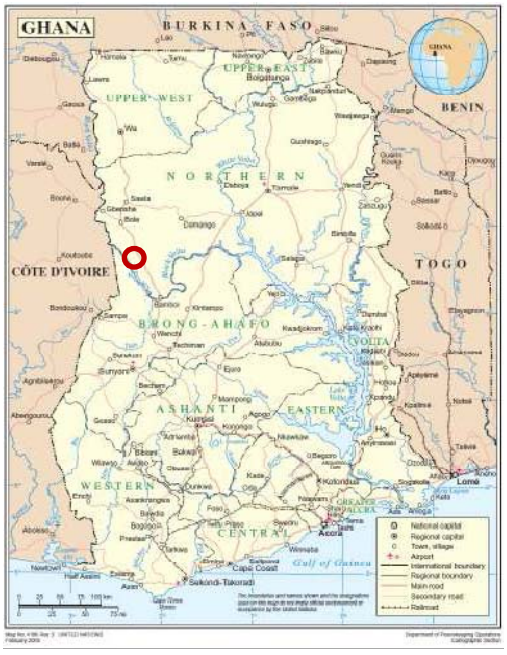
The case that was considered in this present study is women of childbearing age living in rural societies, the Bole District of Northern Ghana.

3.1 Ghana

Ghana was the first African country to gain independence from colonial rule, in 1957. Development has taken place over the last several decades yet this country is still among the poorest nations of the world. On the Human Development Index Ghana ranks as number 152 of 182 countries globally (UNDP, 2009). Fifty-four percent of the population reside in rural areas, life expectancy is 57 years at birth and there exists a high under-five mortality (112 per 1000) as well as high maternal mortality (214 per 100 000 live births) (WHO, 2010).

Much of Ghana's poverty is found in the northern regions due to geographic factors. These areas have harsh savannah terrains and few rainfalls impinging on agriculture and livestock. Regional underdevelopment, low colonial and postcolonial state spending, high rates of labour migration, low underlying agro-ecological potential and lack of access to markets are among other causes for such depravity (Whitehead, 2006). Health care is underdeveloped in this region as well (UNDP, 2009).

Businesses in the southern parts of Ghana, Accra (Ghana's capital) and surrounding areas, account for much of Ghana's growth in economy. Being located near the coast allows for easier import/export and development across sectors including commerce, technology and health. (WHO, 2010) There exists a great divide between the deprived north and the affluent south where opportunities tend to thrive.



[Area of study encircled. Source: www.un.org]

3.2 Northern Region

Much of Ghana's Northern Region is underdeveloped for instance infrastructure,

housing, schools and clinics. Roads are often not paved, full of pot holes and at times impassable due to heavy rains. Villages are remote and it can take hours to reach the nearest clinic or hospital for treatment. This is a major factor in high mortality rates due to treatable diseases like malaria, pneumonia and diarrhoea (WHO, 2010). Toilets are a rare commodity therefore free-range is commonly practiced allowing for frequent cholera outbreaks. Potable water is lacking so women and children must walk (sometimes for hours) to the nearest stream or river even though these are not always safe sources (Avotri and Walters, 1999).

[A village where women were interviewed]

Houses are typically built with sticks and mud so constant upkeep is necessary; especially after the wet season when heavy rains can easily wash away siding and roofing.

Despite lack of resources, it was observed during the field visit that many villages were well kept and clean. Women sweep around their compounds discarding of rubbish and leaving brush strokes patterns in the red stained dirt. Neat piles of stacked fire wood lie near fire pits and clothes hung on lines to dry in the sun. Of course not all villages were like the ones we witnessed. Some of the locals commented that some [Traditionalist] villages are filthy, *'a canteen for diseases'* (Key Informant), from decaying animal carcasses hanging in idol worship and offerings. Humans are forbidden to go in shrines so those areas are never swept or cleaned.

3.3 Northern Ghanaian women

Life for women in Northern Ghana can be very difficult. Most girls do not have the opportunity to attend school; many villages do not have one girl who has passed grade level six of the local primary school (GRID-NEA, 2009). Most women marry at a young age bearing several children during their lifetime. Though reproductive health issues are not the common problem women discuss, most have lost one or more of their children.

In the north, men tend to marry several wives. Unfortunately when he dies, he may leave behind as many as four wives and several children. There is no social security so women have to depend on struggling families for assistance. Typically a widow will be dispossessed

of her home, any possessions she shared with her former husband and her male children. She will be sent back to her village of origin to fend for herself and her female dependent children. (GRID-NEA, 2009)

The majority of women suffer from body aches due to the painstaking physical work they endure daily (Avotri and Walters, 1999). A gender division of heavy workloads is present throughout the villages where women not only tend to the household, cooking and cleaning, but also engage in income generating activities such as farming or selling goods along street sides and markets (Manuh, 1994; Awumbila, 2007). The average rural Ghanaian woman earns roughly 20 US dollars a year (GRID-NEA, 2009).

[Woman pounding cassava for fufu, a local food]

It is common to find women participating in several activities simultaneously to provide for their family. These activities include animal husbandry, gari making (local brew made of processed cassava), shea butter lotions and creams (processed shea nuts). Charcoal burning used to be a major income generating activity for women, however due to recent bans to promote environmental sustainability there was a huge reduction in practice (Manuh, 1994; GRID-NEA, 2009).

Mental health problems occur frequently among Ghanaian women such as thinking and worrying too much. These cause problems such as tiredness and not being able to sleep (Avotri and Walters, 2001). In one study done by Avotri (1997), women's accounts of their money problems, the nature of their roles as wife and mother, and their relationships with their husbands were cited as the source of their distress. Though Ghanaian women live hard lives, you do find many will smile in passing. They socialise together during their work, singing and laughing.

4.0 Methods

4.1 A case study design

This study implemented a case study design collecting data through focus group interviews, key informant interviews, personal observations during the field visit as well as information provided by the local NGO, GRID-NEA [http://grid-nea.org/], established in and working with the women where the study took place. A qualitative approach was chosen as a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem (Creswell, 2009). By selecting a qualitative method, the researcher was able to draw on observations and experiences with the women in their environments to reveal major themes and commonalities. With an open-ended approach there was no limit to measurements on a scale, rather participants influenced the course of research.

Case studies are a particularly well-suited method when the task is to obtain knowledge about a person, people group, institution or describing general phenomena (Kvale, 1996). The case study design is used mainly in social science research where researchers explore in depth programs, events, activities, organisational functioning and processes (Creswell, 2009). Cases are bound by time and activity and researchers collect detailed information using a variety of procedures to collect data over a sustained period of time (Stake, 1995).

Focus group interviews come from personal experience rather than systematic investigation (Morgan and Krueger, 1993). Focus group interviews were used in an effort to create a group dynamic to enhance the possibility of people speaking candidly about topics which participants may otherwise not do on individual level (Vaughn et al, 1996). However, the researcher and fellow colleagues found during the interviews it was easier for them to direct the group rather than allow the women to do so for the reason that many of them had never experienced an interview like this before. Merton (1987), known as the father of focus group interview, states two roles for focus group interviews to (1) find out each person's point of view while encouraging people to express different points of view and (2) to obtain people's opinions but not determine the exact strength of their opinions. So even though the author and colleagues directed the interviews, the women were able to explore their own views as they reacted to others in the group.

Key informant interviews provide insight from experts of the communities. It involves interviewing a select group of people who are likely to provide needed information, ideas and insights on a particular subject (Kumar, 1989). These people work within communities ranging from NGO workers, community leaders, professionals and residents. The key informant interviews were very beneficial in crosschecking responses from the focus group interviews.

4.2 Timeline for project

The project originated in late 2008 after the WHO Commission on Social Determinants of Health was published. SDHVPR group meetings were held from January 2009 to May 2010. Sampling, pilot-testing and data collection took place from January to April 2009. Interviews were carried out in late April 2009. Transcriptions and analysis took place from July 2009 to March 2010. The write up and completion of thesis was end of May 2010.

4.3 Subjectivity

More important than the dichotomy that has arisen in the scientific literature between the value of quantitative and qualitative research methods and the question of objectivity versus subjectivity, is the fact that all scientific research, if it is to be considered valid, must employ and be able to account for the use of rigorous and critical standards in the generation of sound knowledge (Silverman, 2005). It is unavoidable that the qualitative researcher brings personal interests, values, experience and theoretical background to a study, all of which may influence, in varying degrees, the entire research process from the choice of topic to the presentation of findings (Malterud, 2003). It is also imperative that a qualitative researcher is aware of how personal perspectives and theoretical understandings may reflect on the meanings derived from the data. Taking into account and openly stating this to the audience allows for loyalty to the respondents' voices as well as preserving the study's integrity.

4.4 Ethical considerations

In qualitative research the delicate nature of the closeness a researcher has to the subjective life world of individuals brings with it the possibility of inflicting harm, directly or indirectly, on participants (Miles & Huberman, 1994). There were many ethical issues to consider in this specific study, one of the most important being the participants' involvement. The women

needed to understand the purpose of the study and questions being asked. As a researcher it was imperative to remember the vulnerability of these women as well as the fact that many were illiterate. Therefore the project was explained orally in addition to oral permission requested at the beginning of each focus group. The option to withdraw at anytime was permitted. These precautions allowed for comfort and assurance that all information shared would not be used against them in any way. The translators signed forms confirming that the women had been informed before giving consent to being interviewed.

This process was recommended and approved by the Norwegian Statistical Data Services (NSD), which gave ethical clearance for the field visit and data collection. The researchers also asked the Norwegian Region Vest biomedical ethics committee (the regional affiliation of the University of Bergen) to decide whether or not there was any element to the study that would require a biomedical review of the study protocol. The committee waived the review finding no biomedical element in the study. In addition, an obligatory application was made for review to the Ghana Health Service Ethics Review Committee; no agency in Ghana exists for a review of non-biomedical research protocols for a project such as this. The researchers received no response to the inquisition, and on the basis of the clearance by NSD proceeded with the data collection.

There were several issues to consider regarding vulnerability of the participants. Living in such poverty, hopes of receiving support might be expected if cooperating with outsiders who have resources. Thus, information given to participants before the interviews specified that there were no such resources to share with them, but that their contribution could help women living in poor ruralities by gaining knowledge for development workers in the future. The researchers were also aware of possible emotional stimulation from sharing information about the women's experiences. These issues were considered and discussed with the leaders of the local NGO. The leaders advised that as part of the culture, the women would appreciate being asked openly about their lives rather than being reserved. Actually, as experienced by the researchers, the main ethical challenge faced was to find ways to organise the discussions so that all women, not just those who were dominant, were given the opportunity to speak. The women actively participated, showing interest in taking part of the focus group interviews on their own will.

Creswell (2009) identifies good ethical decisions when a researcher analyses and interprets data such as anonymity of participants, amount of time data is kept, ownership of data and accuracy of accounts of the information. When reporting results, ethical issues taken into consideration are maintaining an unbiased use of language or words as well as the potential of suppressing, falsifying, or inventing findings to meet certain needs of research or community.

It would be unethical to not publish results of this study as these findings are essential for the *Social Determinants of Health in Very Poor Ruralities* collaborative project. Therefore, this report will be available for the public by authorisation of the University of Bergen, in Norway. Efforts have been and will continue to be made to publish articles for access through research journals. As part of a larger research group, access to the other studies in the SDHVPR Project may be available upon request.

4.5 Sampling

Purposive sampling was used to locate an NGO local to a rural area of Ghana willing to partner with our research project. Successful collaboration was made with a local NGO in the Northern Region of Ghana, GRID-NEA. This NGO organises, funds and sustains local women cooperatives in an effort to empower women in the region. Activities include groundnut farming, animal husbandry and developing skills and knowledge in agriculture and health. (For additional information see Appendix III, p. 67.) Board members, Dr. David and Brenda Mensah, arranged for all focus group interviews in villages of the Bole District as well as key informant interviews with their workers. They advised on questions, clarifying what was appropriate to ask of the women in these areas.

4.6 Data collection

The interview guide used was semi-structured, neither solely open nor closed ended questions. This gave the possibility of stimulation from responses as well as synergy allowing for any new questions to arise (Vaughn et al, 1996). To inquire suitability of the interview guide, a pilot test was first conducted with 50 women who at that time were on NEA's project site in Carpenter, Ghana for their cooperative training programme. This was for preparation of the focus group interviews though information shared was considered during analysis. Four focus group interviews in total were conducted- two groups each day in two northern

Ghanaian villages. These four groups previously existed as women's cooperatives. All focus group interviews took place in the village where the women reside. Key informant interviews were conducted on NEA's project site over two days, depending on availability of workers during the visit. Similar questions were asked in key informant interviews however, more candid inquiries were sought and personal reflection of their lives and work in these villages. Again, these interviews were to add and to confirm data gained in the focus group interviews. All of the interviews used sixty to ninety minutes.

Each interview was recorded with a digital recorder and cassette tape recorder. Before each interview, participants were informed of and authorised to record. For validity purposes all focus group and key informant interviews had one moderator, Torill Bull, and two note-takers, the author of this report and colleague, Mary Duah-Owusu. Mary is Ghanaian so she was able to understand much of the local language spoken between the translators and women. The author took contextual notes, mostly nonverbal like body language, moods and incidents during the interviews.

There were two translators, both native to the area and fluent in English and the local Mo dialect, translating all questions and responses. They were restricted to only translate what was said and not to add or take away from the dialogue. A Bible translator, from English into the local Mo language, who was not present during the interviews, translated and transcribed recordings from all interviews. These transcripts were then sent via post to Bergen for analysis and further study.

Focus group interviews were implemented openly allowing the women to speak freely. At times the moderator had to interject to bring the conversation back to the main topic. Each interview was started by the researchers sharing about their own lives and families to establish a sense of rapport and allow for easier conversation. According to Vaughn (1996) and many qualitative researchers, it is important to do this as it builds trust and respondents will more likely be candid. At the end of each interview the women were given a small gift (silk flower brooches, bracelets and postcards) as a token of thanks for offering their time and thoughts with us.

Key informant interviews were carried out at the NEA project base, using the same approach for recording and note taking as in the focus group interviews. These interviews were done in English, as the interviewees were all fluent in English. These interviews were transcribed by the researchers. Three key informants, two female and one male all in their twenties, are staff of NEA. Two grew up in villages near the project site and one grew up in a similar context from Eastern Ghana. All three informants have higher education. In the result section, key informants are referred to as KI-1, KI-2 and KI-3.

The other two key informants are Dr. David and Brenda Mensah. It was difficult to protect anonymity due to their roles, however this situation was discussed with them and they confirmed it not problematic. David is a native of the Bole district and completed his doctoral degree in Canada where he met his wife, Brenda. Brenda is Canadian, living and working with the people of these villages for over two decades now. They are referred to as KI-D and KI-B in the results section.

During the entire week, the researchers spent many hours in casual conversation with NEA staff as well as David and Brenda, whom daily meals were shared with. Notes were taken daily of these experiences and observations during the field visit, including interesting information obtained through our informal talks with people.

4.7 Analysis

Various styles of analysis in qualitative research exist without one being more precise than another. Ultimately it is the expertise and interpretative skills of the researcher that play the most important role (Kvale, 1996) in such a manner to present an interpretation of the larger meaning of the data (Creswell 2009). Creswell's (2009) approach for data analysis suited the author's novice skills in qualitative analysis best with six straightforward steps. These steps include: organise and prepare the data; read through all the data; coding; description of setting and creating themes from coding; interrelate themes and description; and interpret the meaning of themes and description.

The first step took team work as the author and colleagues worked together to gather all the field notes and transcribe recorded interviews. This was a tedious process as precision was

crucial to maintain authenticity of the oral interviews. By checking each other's work this was done to the best of their ability. All transcriptions were saved in separate files according to each interview and day. Names and places were omitted to keep anonymity of all participants.

During this early phase of analysis, the author continually read through all the data to familiarise herself with the information. The author would note repetitions, significant accounts and major themes. This allowed for the author to reflect on the overall meaning and to comprehend what the participants were revealing from their responses. Notes were taken while the author read over the transcripts. These notes were also reviewed over again to pull out any commonalities or early interpretations.

Though the process easily flowed into coding, the author spent a large amount of time in this phase. First, the author grouped notes and direct quotes of participants thus eventually ending up with about twenty categories and several overlapping. Some of these groups included *family dynamics*, *gender disparities*, *cognitions* and *dichotomy*. It was unclear at this point how to organise these categories to present them in a manner to answer the research questions. However being part of a larger working group had its advantages, one of those being weekly discussions and collaboration on strategies to present the data. Though each member researched diverse contexts around the world, all members were in search for social determinants of health of women and how they strive and thrive despite adversity. So together, the author and other group members decided collectively to do use the capitals found in the SLF model: *natural*, *physical*, *financial*, *human*, *social*, *cultural*, *symbolic* and *political*. From here the author continued to read thru and analyse the material and earlier codes to then categorise them under the capitals.

The group meetings were essential at this point as members worked together to keep their own context in focus with relation to the SLF. Many times the author found herself deep in the data pulling out various segments and moving into different directions. Constantly she reminded herself to stay focused on the questions and themes (capitals). While strengthening these themes and descriptions, the author highlighted which capitals were most relevant to this case study. Questions were asked like, 'what were the lessons learned?' and, 'how do my themes fit in the SLF model?' and, 'am I able to answer the research questions proposed?' The following chapters discuss these results and interpretations of such.

5.0 Results

The purpose of this case study, as earlier stated, was to define and identify contributing factors and influences of social position and status on health among Ghanaian women of child-bearing age, residing in the Bole District of Northern Ghana. This chapter is presented in accordance with the eight capitals of the sustainable livelihoods framework, as described in chapter 2 (natural, physical, financial, human, social, cultural, symbolic and political). The data collected comprises of focus group interviews with local women, interviews with key informants, personal observations as well as information provided by NEA's website (www.grid-nea.com). The data exhibit aspects of women's daily living and social life that could very well impact their status and wellbeing. Quotations by the women were translated from their local dialect into English whereas all key informant responses were direct quotes in English.

5.1 Natural capital

This section is brief since there was only minor evidence in the interview data of a significant relation between natural resources and women's health or status. Observed data as well as information found on NEA's website (www.grid-nea.com) did reveal an important indication that natural capital does impact the health of women in the Bole District. Natural capital consists of resources found in nature such as water, air, forestry, etc. The environment creates a vulnerability context, an important element found in the livelihoods framework from chapter 2. A threat to women in this region did exist as the harsh climate affected harvest and food supply. In years of drought, crops were destroyed impinging on the women's farming. As a means to cope, NEA introduced animal husbandry to the women cooperatives as a secondary source of income. In addition, NEA successfully developed an aquaculture project which included a fish hatchery and several large fish tanks on the project site. Eventually fish tanks will be constructed and maintained by the locals within villages across the region. NEA also promoted sustainable environments by endorsing laws that forbid charcoal burning to prevent deforestation, along with prohibiting DDT poison as a method of fishing to reduce lethal consequences to humans who utilise the river as a water source.

5.2 Physical capital

Physical capital consists of several basic human needs including water, shelter and security. It also refers to infrastructure such as roads to access health care services. Findings are presented with regard to sanitation, infrastructure and proximity. Previous to NEA's intervention programs, this region in Northern Ghana had minimal physical capital.

> *"Sometimes they don't have good drinking water, they don't have any toilets around, they have to go to the bush. There are outbreaks of cholera, everybody is affected because the villages are packed in the environment with bad practices."* (KI-2)

> *"We have all kinds of diseases that way here, we had guinea worm, we had infant mortality problems, we had hernia, lots of hernia, lots and lots of hernia problems, and we have women who are dying as a result of breaches, problems."* (KI-D)

Sanitation encompassed several components which should be considered to successfully combat diseases in problematic areas. These included access to clean water and roaming livestock which spread disease among animals and humans. Wells, or boreholes, were built to separate clean from dirty water as well as to decrease the distance a woman must walk to access clean water.

Members of the women cooperatives were trained in animal husbandry and financed to buy a goat for income security. NEA encouraged farmers to build fences for their livestock to reduce the possibility of spreading disease through the animals. Although these measures were implemented, the data suggest only slight change has occurred. Several local people are unable to afford materials to build animal stalls.

> *"Pigs are not very clean animals. Around here most of them don't house them. So they just roam like that… Even if you vaccinate yours, and other people don't vaccinate theirs, because they are mixed they can transmit diseases. But when they are near your house, where they are enclosed, you can always monitor (…) there is a lot of money in these livestock, there's a lot of money in it. But sometimes you find that when you go to a community and for a certain year there is an outbreak of this disease, and almost every animal dies. You know, a lot of money is lost."* (KI-3)

In addition to slight change, many local people still preferred water from the river rather than boreholes, as it tastes sweeter. NEA has, however, successfully protected sections of the river with fishing method restrictions, increasing safety for human use and consumption.

Infrastructure was a major necessity that people from industrial societies often take for granted. Roads in this region were commonly unpaved and distances from villages to health clinics were far. In the interviews, women stated they do not go for medical checkups for themselves or their children because it was too costly for many of them. A majority of locals did not own a car or a bicycle therefore walking was the main transportation. It could take several hours to even a day for a person to reach the nearest clinic. During medical emergencies one of the greatest obstacles was transporting a patient to proper medical assistance. The data show proximity was a health impact on women's wellbeing.

> *"Sometimes when they are delivering there might be some complications. And some live so far away from the clinics, there is no means of transport, sometimes you have to carry these women on bicycles – and you can imagine how that is carrying a woman in labour on a bicycle for three or four kilometres."* (KI-3)

Women not only relied on their farms as a source of income and food source, many went to the market to buy and sell. The further the village was from the market the greater the challenge was for a woman. She had to decide wisely how to use her money:

> *"I think about – (the market) should be about 13 kilometres... You know, and somebody is just in Village B, so if a person has (some money) you can just use that to buy fish. But if you live in Village A the person has to travel. What do you use to travel, what do you use to buy the fish? So places where they don't have markets, you know, is a bit challenging, you know, living in those places."* (KI-1)

NEA continues to improve physical conditions in the area with construction of wells, latrines, schools, and health clinics, including maternity wards, nearer to the villages.

5.3 Financial capital

Assets of financial or economic value found in the data included money from income generating activities as well as food security and material possessions. These were deemed of

great importance to the women's wellbeing as they shared experiences of their hard work and earnings to provide for their families:

> *Before the coming of the groundnut program, some of us slept on mats and pieces of cloth. Now we are able to buy beds and mattresses, and clothes for ourselves and children.* (woman)

> *I am weak and widowed, and I have a child in school. The program has helped me to feed and care for my child in school.* (woman)

> *My husband and I were separated before he died, and all the children are with me. What I got from the groundnuts, I sold and gave to one of the children to go to school. I am very glad. I have gained from the program.* (woman)

> *I am able to get money to buy my clothes, and money to buy food stuff, vegetables and meat for soup.* (woman)

Previous to the cooperatives many women, especially the most vulnerable, had no means for income generation. There were no available resources for farming, buying or selling. According to NEA, an average woman's income was approximately 20 US dollars. Since NEA's intervention, women were given opportunities to work and provide for their families. Women participating in the cooperatives earned up to 360 US dollars in their last harvest. NEA's contribution has indicated positive progression for the wellbeing of women.

On the contrary, many women suffered as a consequence of not getting enough nutrients in their diet. The data revealed a diet for most women consisted mainly of carbohydrates with very little protein and micronutrients.

> *"If they eat more of proteins instead of the carbohydrates, most of the food here is just carbohydrates, there's no balance. If they eat fruits, you hardly see anyone eat fruits here. In the southern part of Ghana it is better, because they have a lot of fruits, but here there are no fruits. Hardly ever do you see anyone eating fruits..."* (KI-1)

> *"With the kind of hard work that they do farming, (there is) no good food to eat. I've hardly seen anybody eating meat throughout the week. (...) They don't eat fruit, nothing like protein. All they need is their bellies to be full. And when you eat like that and you go to the farm and work the whole day, so it really affects them."* (KI-2)

Women's position in the family also affected food allocation. Women typically fed their husbands and children first. In polygamous families, ranking order of wife and children played a huge role in privileges. The first wife and children of the first wife took priority over the other wives and children.

Material possessions were very important to the women. In fact, one key informant expressed some women prioritise cloth over shelter. Women saw cloth as a sign of social status therefore felt the need to own such for dress and headwear. Women also prided in the ability to use their income to purchase household items such as cooking pots.

> *I am in my third year of farming. Last year I gave back three bags of groundnuts and sold one bag of groundnuts which money I used to buy an aluminium cooking pot. This pot is great property which I will use to brew our local beer. This will be great income earner for me till I die.* (woman)

These financial gains have influenced the status of women. The data reveal a purpose behind these projects was for men to gain more respect for their wives and even assist with their work load.

> *"That is our strategy for these men to accept that this woman can employ them, just like they employ other people (…). Normally in society it is the man who has the money. We reverse it, we say, you have the power now, the money to employ the men – just to accept them, to see they are important, that we are equal."* (KI-D)

> *"The men can help their women by weeding the fields when we give them their peanuts to farm (…). You give money to the women, sometimes we encourage the women to employ their own husbands to weed the field."* (KI-D)

The women told that their husbands did see their farming as income for the family and demonstrate more respect towards them.

> *Before the groundnut program came, every time I looked up to my husband for everything. When he is hard up, he gets angry when I make any requests. Now that I (have) a little from my groundnut farming, I buy fish for soup and soap to wash our clothes without his knowing. Now there is much more happiness in our home. Before then the least thing I said provoked him to anger.* (woman)

5.4 Human capital

The attributes a person possesses such as skills, knowledge and the ability to work, are regarded as human capital. Addressed in this section are outcomes of human capital on women's health according to *formal and informal education*; *health education and family planning*; *labour and rest*; *illness*; and *wellbeing*.

5.4.1 Formal and informal education

The distinction between formal and informal education specific to this study is *formal* education is based on an official curriculum commonly practiced in developed societies with a grading system and passing of exams to proceed to the next level. *Informal* education refers to training or skills attained outside of any formal setting, for instance through farming, hunting, childrearing, community activities, or buying and selling of goods. Both forms of education were present in the villages studied. Formal education was less common among the people however it was highly valued and many women spend their income on their children's education.

> *I will be happy if my child is successful in his school completion examination. It gives me hope that he will get a good future.* (woman)

> *My prayer is all my children can successfully finish schooling and get employed.* (woman)

> [Mother's reaction of own child completing university] "*She couldn't just believe it herself, she was so happy. Well she goes like 'Eh, how did this happen to my child?' You know, so she is so grateful to God and anytime she speaks she just gives glory to God..., she's so happy."* (KI-1)

Some men did show respect towards a woman who had completed school, especially higher education, however it seemed that level of respect was greater when the man had completed a higher level of education too. For example, one key informant shared an experience at work where a male employee belittled her due to her smaller body size even though she was his superior.

All women interviewed had some level of informal training through their participation in the women's cooperatives. This not only increased their resources but their status with their families and communities as well. One key informant gave an account of her mother's story, who when younger was not allowed to go to school because her uncle did not want to waste his money when she could work on his farm instead. As a result, she worked hard most of her childhood and into her adult life and thus gained respect from others in the village.

Another key informant revealed a common trend with girls between fifteen to eighteen years old. After completing secondary school exams they were sent to larger towns and cities to look for work, 'kayayoo,' to help people by carrying loads on their heads. Unfortunately many of these girls ended up in prostitution, unwillingly. They then returned home to their villages pregnant and forced to adapt to life as a young mother.

5.4.2 Health education and family planning

Health education and family planning was a significant need in this area. The women and key informants acknowledged this necessity during interviews. Too many women did not know how to care for ailing children or family members, prevent the spread of diseases and many desired to bear fewer children.

> *We have to plan to give birth to small numbers of children because living and educating children is becoming hard every day.* (woman)

> *My mother gave birth to 14, but could not educate or take good care of us. If I had my way, I would like only two but it is too late, I have more than two now.* (woman)

Teaching health and family planning from parents to children was lacking as well as between teachers and students.

> *"Because most of our parents are illiterate, they don't know anything. They don't even know about family planning, they can't even tell you 'at this time don't go sleep with this guy' or do this or do that, they just leave you like that."* (KI-2)

> *"They (teachers) tell us, 'go and talk to your mother and she will teach you.' Nobody teaches you anything! And then you go and ask your friend, how do you do this, so you resort to friends more than family."* (KI-2)

Implementing health education programs for family planning and disease prevention might increase the health of women as well as for the men and children too. There was support and funding for clinics and NEA to provide health training sessions, however it was observed during one training session on NEA's project site that the women had little knowledge on health practices and prevention techniques.

5.4.3 Labour and rest

For many women, labour was much and rest was little. The women shared what their days were like living in these villages, quite similar for each. A typical day began in the early hours of the day, before sunrise. They swept their compound (mud huts encircling a common area for cooking, eating, etc.) and fetched firewood and water to boil for the day's chores-cooking, washing dishes, clothes and bathing. After sending the children off to school in the morning, they tended to their farms. A commonly used tool was a short hoe, forcing them to hunch over and vigorously claw at the earth to soften the dirt. Some women would have a baby wrapped in cloth tied to their backs. The farming would last for hours under the scorching sun and by late afternoon, they returned home to cook dinner. They fed their family and prepared baths for the children and husbands. At night, sleep could be interrupted by feeding babies, sick children, and body aches. As early morning approached they had to rise to start a new day.

> *Sometimes when you wake up, you are tired, but you have no choice.* (woman)
>
> *What choice do we have? That is our work. No one will do it for us.* (woman)

Most of the women and key informants asserted that women worked harder than men. Even though both worked hard on the farms, the women returned home to continue household work while the men socialised.

> *We know that men are stronger than women. At the farm, women work like men do and when they both come home women still do the house chores. This is why we say women work more than men. Sometimes it is the woman who takes bathing water to the bathroom for the man.* (woman)
>
> *"That is one thing a lot of men don't know how to do, they haven't learned how to do it. They prefer to go and sit and chat with friends and only come when food is ready." (KI-3)*

> *"They would be healthier if they had also their husbands helping them do some of the hard work. A woman will have to carry firewood, you know... So if you have a husband who can help you, you know carry some on the bicycle, you know it would release them from their stress, she would have to carry this, so you are always hearing her complain my back is paining me, you know. It is hard work, it is always giving them these aches and hard things."* (KI-1)

Balancing labour and rest would more than likely improve the health of women. For generations the roles of men and women have been quite defined. Redistributing household responsibilities have shown a positive effect according to NEA and the women involved.

> *Some men are helpful. He can come up with some work and say let us both join hands in this work for our common good. Sometimes he helps you in bathing the children or in some house work. Then together you both converse to the farm. It is simply nice so.* (woman)

> *If he talks to you in a loving way, that alone makes you happy. If you have 2 children, on the way to the farm, he can carry one child and you carry the other.* (woman)

5.4.4 Illness

When asked whether illness or tiredness was worse, the women unanimously agreed it was better to be tired than ill.

> *I am ill, but when I rise from bed, I pray thanking God for the new day because not all sick people wake up and are able to rise up and move. So therefore when I wake up I am happy.* (woman)

> *Sickness is a problem, but when you are tired and you sleep and rest well, you are strong again.* (woman)

Though all women experience tiredness often, they considered illness a greater threat. If sick they were unable to work therefore unable to provide for their family. However, if they were tired, they were still capable of work.

None of the women knew anyone who was completely healthy and they affirmed that all women suffered from some kind of ailment. The most common were backaches, headaches,

hernia and eye problems. There have been medical treatments for hernia, yet treated women could not abstain from their work for the requested amount of time to properly heal, consequently many women had reoccurring hernias.

> *We are really not very healthy. We only persevere. As I sit, I feel pain in my spine, yet I will go to the farm with the pain. If not I will not get food.* (woman)

Other illnesses impinging on the health of women included malaria, STDs, which could make a woman sterile affecting her status and wellbeing, and complications from improper prenatal and antenatal care. With so many life-threatening health concerns in these villages, one can easily understand why tiredness was preferred over illness.

5.4.5 Wellbeing

Despite the hard work and suffering these women endured, often times you would hear laughter among them, smiling faces and at times a wave of the hand when you greeted them. A major element of the SDHVPR project is searching for protective factors of women's wellbeing. The women and key informants were asked what makes a woman happy because of the researchers' observed moments of women expressing this sense of joy through smiling, joking and singing. The women responded with:

> *I will be happy if my child is successful in his school completion examination. It gives me hope that he will get a good future.* (woman)

> *My happiest moment is when I have food in stock and when my children cry for food and I don't need to look to anyone, and I can lay hands on my own stock and feed my children.* (woman)

> *When I wake up and I do not hear any report about illness from my relatives and my family, and in addition I get something for food for them all.* (woman)

> *I will be happy if my husband returns from the market place, and he brings a piece of cloth and says, 'Take this cloth to cover yourself and your child.'* (woman)

Moreover, the key informants shared:

> *"Life is tough here. But, there is also more joy here. I think it is a fact. That even with these scanty resources, I have dealt with these poor people to know that deep inside*

them, they bring out more gold from their life and from their way of existence, than what finances does for people. That is a fact." (KI-D)

"You know, they just accept the situation, like it's part of us, that is how it has been since the beginning, that's how my grandmother was, that's how my mother was, so they don't have a choice. They are happy, they are used to it, it's been part of them. They don't see anything different or wrong with that. They are ok." (KI-2)

"I often notice that there are healthy and happy women, in spite of the challenges some still are healthy. But not as many as those that are unhappy." (KI-3)

Though many women expressed happiness, this did not conclude all women were happy, just as one key informant stated above. Women repeatedly responded with experiences of illness, tiredness, loneliness and pain.

5.5 Social capital

Social capital incorporates relations, networks and associations of people. This section indicates women's relationships with their husbands and children as well as others in their communities. The last part recognises social changes that have emerged in the villages which data show has had an impact on women's social resources.

5.5.1 Women and husbands

The data disclose the relationship between a woman and her husband greatly impacted her health and wellbeing. The women agreed that they felt happy when their husband assisted with their work as well as when he spoke affectionately to her and supported her.

We all depend on the produce of his farm. But he sometimes leaves his work to help in my work. He buys clothes, soap and meat for soup. (woman)

My husband helps me with preparing meals, washing of clothes and mopping of the room. (woman)

After the days tedious work if he can talk to you sweetly or say words of encouragement or even massages your aching body with warn water or some medicine, it is nice. (woman)

Women also spoke of contrasting incidences with their husbands. It was custom for the husbands not to help and because of that a woman must accept it.

> *No, they do not help us- at farm or at home. After the day's farm work, you have to prepare the means, bathe your children, etc, all alone.* (woman)

> *At farm work the man does help sometimes, but with housework he does very little to help.* (woman)

> *It will really be good if they could help with some of the house chores, like bathing the children and taking them to school.* (woman)

> *It will be very good, but the tradition here does not make them do it. So we take it like that.* (woman)

Women can be very competitive in polygamous marriages and the rank order of each wife impinged on her and her children's health.

> *"You know, there is favouritism, there is favouritism for children, if you talk to children that were part of such systems, one would say 'Well my mother was my father's favourite wife' or the other ones will be saying 'We really suffered, for my mother wasn't his favourite wife.' So there is just so many different things that they face in there. I believe that those statistics are being depressed and maltreated, we'll see much more of just maltreatment of women in their situations."* (KI-B)

One key informant described the effect of her parents' relationship with each other on her and her family:

> *"...it nearly had a negative effect on me because I didn't even want to marry. I just wanted to become a woman sister. Because all I saw in the house was my mother fighting my dad. They would almost every day fight, you know, all this fighting in the house. (...) So I never had the desire, because I knew that was how all men were, even if I didn't see some people fighting in their homes. It really had an impact on me. I had a sister who talked to me, then my mind's changing."* (KI-1)

> *"From her experience, from the things she told us, it has become my brother to become like, 'mom, you have really suffered, I wouldn't wish to treat my wife like*

that', and he'd go like 'what my dad did was very wrong.' You know... and 'that hurts you, and I don't want to repeat that to my wife, it is so bad.' (...) So he has some kind of respect for people who have really been able to stay in marriage." (KI-1)

Although men from these villages still practiced traditional roles of little or no assistance in the home, transitions have occurred where some men shared in household duties. Data suggest this has positively impacted women's wellbeing.

One burden on women's health that emerged from the data was the loss of a husband. Though many women took part in different income generating activities, the husband's contribution was very much needed. The death of a husband could severely affect a woman.

My husband used to help pay the children's school fees and solve all the family problems. When he passed away leaving me alone, it was very hard. (woman)

When your husband dies leaving you and your children, no one helps you. You become the bread winner of your children. No one helps you. (woman)

"While your husband was, you know, alive, if he wasn't worthy, and any member of the family that came he sent them away, they will not allow her the husband's farm or anything, you know, in those situations when a man dies, they will not treat you well, no one will assist you." (KI-1)

5.5.2 Women and children

Children were a valuable asset to most all women in these areas. They were regarded as helpers for the family, another resource for generating income. Though children were most demanding at younger years, they were reared with intentions of succeeding in order to later provide for their families.

When children are still very young, it is a great burden to bring them up, but when they are grown up, they are able to support us in some house work, and to look after the very small ones. (woman)

...Sometimes she can sell things and get money, and on return home she can buy a pan or a handkerchief for you. Sometimes she can buy some meat for you to prepare meals... (woman)

> *"It is a good thing. You know, because the children they are not grown, they are all small, small, between the ages of one to eight or nine. They are all small, small, they can't do anything to help her, they can't farm, can't do anything (...) When they are much older, they are grown or they can help you, no one will ask to assist you. Because you will be really happy to have them around you, they can go for water, they can assist."* (KI-1)

Children's education was very important as women spent most of their earnings on their children to attend school and take exams.

> *The groundnut program has enabled us to help our children in school.* (woman)

> *I am weak and widowed, and I have a child in school. The program has helped me to feed and care for my child in school.* (woman)

> *If your children are only a few and you look after them well and educate them, they can be employed after school. When the child gets her monthly salary, she will help you by buying some things for you. It makes a great positive difference from not educating your children because of their large number.* (woman)

The loss of any child greatly affected the mother in various ways. The women emotionally conveyed their feelings of losing a child in addition to the financial burden it imposed.

> *It is very painful. I cannot even talk about it because I feel like crying when I think about it. My husband died, and in 2 weeks time my child also died.* (woman)

> *I looked after my child in primary, junior secondary and senior secondary schools. I spend a lot of money on him in that. He became ill and I spent all the money I had on his illness for 7 months. I had to sell my clothes to get money to pay his health bills. In such a situation, why will you not cry if at the end such a child dies?* (woman)

> *If you gave birth to your child the same time with someone and your child dies, anytime you see the living child doing something for her mother, you feel like crying. You know if your child were alive, she should have been doing the same for you.* (woman)

> *Child death is painful. Every time before I arrived from farm, she had prepared everything nicely at home, like fetching water and beginning to prepare meals. Being tired from farm, all that I had to do was to bathe and rest. She could go to market and buy everything we needed. So losing such a child, I never forget her. But I know God gave her to me and He has taken her away.* (woman)

It was confirmed with the women that the gender of the child was not significant. Previously, farming was the only source of income and boys were preferred. However, this was not the case presently because education was well-regarded with both boys and girls attending school.

5.5.3 Women and community

The data depicted contradiction with women's relationships in the community. The women described inabilities to ask for assistance:

> *There is no one whom you can go to for help. Even when your brother/sister is wealthy, when you are in need, you can only remain in your room and brood over your poverty. If even you go to him, he won't help you. He may even expose you and your poverty to public after hearing you.* (woman)

> *Your sister will not help you even if she has. She will go around spreading what you came to plead with her for.* (woman)

> *It is not advisable to approach people for assistance. They will not help you, but will go about discussing you to people. It is therefore better to keep your poverty to yourself, instead of discussing it to people.* (woman)

Whereas the key informants' responses emphasised that the communities do help as well as generosity of people in the villages:

> *"Yeah, there is a support. Because, like they have a system where they harvest fresh yams, even when you have harvested fresh yams, what you do is you are supposed to give every widow maybe one or two tuber, that is what they do, that after harvesting you give each old lady, especially the very old ones and widows, you give them a tuber each, one or two tubers each, so there is some kind of help."* (KI-1)

> *"Well, in some villages they have this communal work system, where they come together and say, "Well, let's go to C's farm today, we'll go to her farm and help her, and do everything for her, and then tomorrow it's my turn, we go to my farm". Sometimes the whole village come together, they want to do something for the benefit of the village.*" (KI-2)

> *"Often the women peanut farmers, when they are in a group, five or six of them will try to get their land close to each other so that they can go together and they will help one another when they do things like that."* (KI-B)

It was evident that women did receive support in various circumstances. However, assistance might be restricted due to limited resources of others living in the same villages.

Friendships between women also existed and some said they would go to a friend for comfort if lonely or sad, while others said they would not for fear of spreading rumours or making comments to worsen their sadness. One key informant told of her mother's belief of such:

> *"There's no secrets between two people you know. (...) If you want something to be secret than you should keep it. So she doesn't really want to share anything secretive with anybody, you know. She is free with people, she is friendly, she loves people... but people come to her to share their problems, to ask her questions, but you wouldn't find her doing it."* (KI-1)

Women who were hardworking and trustworthy were shown respect, where as women who were lazy or known to gossip were not. Those who have gained respect from other women were sought out for advice.

5.5.4 Social transitions

The data reveal several transitions have developed by means of interventions from NEA empowering women with income generating activities as well as influences from larger cities to the rural villages. These can be perceived as both good and bad. Women have acquired new opportunities to provide for their families and more possibilities for access to health care. Education was spreading throughout the villages and values were shifting as schooling was becoming an important investment for families. As stated already, the relationship between husbands and wives were changing and men were more helpful with their wives at

home and with the children. The spread of religion has altered beliefs where previously men had more privileges than women impinging on their health.

Despite positive progress in rural communities, there were negative outcomes of these modernisations on the people. For instance, some key informants shared how compounds that once housed multi-generations were diminishing as a requirement for men to marry was to build a home for a single family. Consequently, support—food and care giving—for older family members has decreased because these members were no longer looked after or thought of when providing for households. The community support that once existed was shifting to more individualistic societies similar to those found in larger towns and cities.

5.6 Cultural capital

It was clear from the data that cultural capital had evident influence on women's health and status. Traditional customs created gender disparities where men had more opportunity to thrive while women struggled. Religion was a factor of women's wellbeing as certain practices ceased when Christian and Muslim faiths emerged. The three religious groups lived peacefully together in the villages however differences between them revealed substantial affects on the health of women. Traditionalism, or fetishism, originated in the area creating a male-dominate society. Men established laws usually favouring them over women and children. Fetish priests had great power over others and idol worship forced people to sacrifice most of what little food existed. The people lived in fear, men and women alike:

> *"There is a lot of fear, a lot of fear."* (KI-D)

> *"Fear is one thing that very much affects them, women and men, it very much affects them."* (KI-B)

Men benefited the most as they were allowed to eat chicken and eggs, a rare and important source of protein. They ate before women and spoke before women.

> *"They have all these rules that say, you know, 'women cannot eat it,' 'children cannot eat it' and so, I think it causes, it causes a lot of problems, for the families. A man or a woman could take everything they have when a fetish priest tells them that 'If you don't do this, this is going to happen.' They don't mind taking all they have to just neglect the children, and go and give it to the fetish priest."* (KI-D)

> *"That's right. Women does not eat eggs, you know, you know and a whole lot which I think are not helping the women in the typical traditional homes that is – the taboos, there are just too many, and they are all negative. That affects the women."* (KI-3)

When the Christian and Muslim faiths were introduced, many people converted in search for a life without fear and deprivation of food.

Traditionalist villages are unclean as one key informant explained:

> *"Differences are sharp. You see the Christians there is a lot more vitality and even cleanliness, you can go into a fetish place, the whole place is just a canteen for disease, you know, you see heads of sacrificed dogs and goats hanging all over the place, of course for most of the shrines and there are rules and humans are mostly forbidden to go in there."* (KI-D)

Another custom affecting the health of both men and women were funeral celebrations. When someone died, everyone had to stop their work to come together. They were required to bring food, drink and gifts, many times depleting their entire stock. This practice burdened the people as they left their farms unattended and used up their food sources several times in a season. A new law, and well received in the villages, has enforced only three funerals a year per village to reduce the negative health impact on the people.

5.7 Symbolic capital

There was little data that confirmed symbolic capital had an effect on women's wellbeing. One key informant acknowledged that cloth was highly valued among the women as it showed a sign of status. A cooking pot was also considered important for a woman because it gave her ability to provide for her husband and family- a means for cooking as well as selling food and local brew.

5.8 Political capital

Recent advancements in the region have impacted the health of both men and women. A significant factor in the process was that NEA's director, Dr. Mensah, was also a tribal chief and highly respected among others. With his desire of sustainable development, his level of power permitted him to negotiate deals with other chiefs in an effort to help the people. This

included successful peacekeeping discussions and signed deals, funeral changes as earlier explained and outlawing practices that were harming the people. For example, the use of insecticide poisoning for fishing purposes in the Black Volta River as well as deforestation for charcoal burning. Although some of the women and key informants complained that these bans impinged on their income generation, efforts were being made to substitute other activities for profit.

Women participating in NEA's projects were also encouraged to take leadership roles in their communities allowing them opportunities to take part in local councils. One key informant shared of three women who had been elected to the District Assembly. Additionally, older widows who were previously at risk of ostracization were now provided with a place next to the elders of a village after their successful roles as 'agricultural consultants' in the village.

Another key informant described the health benefits of good leadership within communities:

> *"You go to some communities and you just enter into the community, you know that these people are decent too. That I think has to do with leadership in the community… So you find these vast differences in sanitation. And that basically has to do with who leads them. Somebody should be able to call all of them to communal labour saying, 'Look, our town or village is dirty, let's clean it up.' If nobody says it, sometimes that is responsible for those sicknesses and diseases."* (KI-3)

Summing up, the findings presented above indicated existing connections between social determinants and women's health. This study showed that the ability to bear children, traditional skills, education, religion and social status were strong indicators that affect the status and wellbeing of women of childbearing age. Many of the women and key informants pointed to social position as well as respect from others as having an effect on the overall health. Several elements within the field of health promotion emerged from the findings of this study. These include empowerment, salutogenesis as well as influences of globalisation. These intertwined and sometimes complex concepts can be recognised as effective means to promote health, even in the direst of living conditions. In the next chapter, the findings of the study will be discussed with regard to these three themes.

6.0 Discussion

The aim of this project was multifaceted. First, it intended to identify social determinants of health in very poor ruralities; second, to explore the protective and enabling factors for wellbeing of women in these communities; and third, to investigate the characteristics of a thriving woman. The research questions asked what defines social position and status, what factors contribute to social position and status, and what influences do social position and status on the health of Ghanaian women of child-bearing age residing in the Bole District of Northern Ghana.

In order to answer these questions, identifying social health determinants was achieved by using the framework (SLF presented in chapter 2) so as to code the data within the context of the eight capitals. These capitals focus on various resources that a woman possesses in order to manage daily living, coping with vulnerability and building capacity to reduce their level of poverty. The findings from this study demonstrated that these capitals can, and in fact do, affect women's health and status.

Financial capital had increased due to the implementation of the women's cooperatives. Income generating activities allowed women more economic resources for providing for their families. Although this improved women's status many still lacked nutrients in their diet impinging on their health. Prior to NGO intervention, physical capital was almost nonexistent in the region. Sanitation or lack thereof, caused many outbreaks and spread of disease, like cholera. Access to health care proved difficult because of poor infrastructure. Natural capital exposed threat to women's livelihoods as harsh land and climate greatly affected farming. The introduction of animal husbandry was a secondary source of income in case of drought and the destruction of crops. Human capital indicated that the ability to balance labour and rest would more than likely improve the health of women. Health education and family planning was lacking in the villages and the need for such programmes was evident. Social capital emerged as a great influence on the women's status and health. For example, support from husbands was highly valued. Many women reported they were happy when their husbands assisted in their work load. Other women expressed the negative impact caused from the death of a husband; the hardship of having to generate money and raise children on their own. Cultural capital also revealed a health impact on women, especially when traditionalism previously dominated the region and women were marginalized, depriving

them of essentials, like nourishment, to survive. Although symbolic capital had minimal findings women took pride in their achievements and the ability to buy cloth with their earnings gave them a sense of beauty increasing both wellbeing and status. Political capital influenced women's status as they were encouraged to take leadership positions in their communities, even participating in district assemblies.

The discussion moves further into detail on how other elements of health promotion emerged from the results. Still keeping in mind the framework and capitals, the discourse illuminates the influences and impact of empowerment, salutogenesis and globalisation on social determinants of women's health and status in the studied communities of the Bole district.

6.1 Empowerment

Empowerment is at the heart of health promotion. It is the process of enabling people to take ownership of their life situations in order to live healthy. Since the Ottawa Charter (1986) the public health arena has promoted empowerment as a means to help people help themselves. Not only can people take control of their own lives, they can do the same within their communities through social support and public participation.

Individuals' choices can be limited by circumstances beyond their control. As a result, policies in all sectors, including the private sector, are a necessity to create environments that support healthier lifestyles. In health promotion, there is an emphasis on empowering people to control their own health and to identify and solve health issues as their own priorities. Health inequalities within and between societies become worse by social injustice, therefore health promotion is forced to enter the political arena and advocacy for social change is an important health promotion strategy. (Mittelmark et al, 2008)

In the region where this study took place, NEA has partnered with both the Ghanaian and Canadian governments as well as regional and local authorities to advocate for the people living in such impoverished conditions. NEA has focused on empowering women by introducing income generating activities as well as teaching both women and men ways in which to work together to build capacity and resources. Initially, women in these villages had no control over their situations. Living in a male dominated society, women had minimal opportunity to thrive. The establishment of NEA has brought transformation as women are

able to participate in the women's cooperatives to create sustainable livelihoods. The primary objective for NEA, which stands for Northern *Empowerment* Association, is to strengthen the position and status of women as they are found to be the most vulnerable.

The findings in this study confirm a significant impact in the lives of the women participating in the women's cooperatives. For instance, women frequently gave accounts of how their income generating activities provided them financial capital for provisions, like food and household items, in addition to education for their children. Political capital also increased as women were appointed positions of leadership by NEA, 'agriculture consultant' for their village, giving them more responsibility and increasing their status.

Health promotion programmes are most successful when linked to the normal daily life of communities, building on local traditions and led by community members (IUHPE, 2007). NEA has successful implemented programmes within the villages of this region because of their bottom up approach. The director, a local from the area, is familiar with the cultural and how to introduce alternative methods for healthier living that will be accepted by the people. Not only do they provide income generating activities, they are tackling health issues with an integrated approach- to consider all causes of poverty and not just focus on one sector. NEA has created new opportunities for the women to learn and take ownership of their situations.

Although these programmes have increased women's capacity, at individual and group levels, not all were completely satisfied. In one of the villages, women complained that they would rather be funded with a loan or grant for small business ventures, to be able to buy and sell goods at the local market nearby. This demonstrates the importance of knowing the target group. When implementing new programmes, it is crucial to understand how the communities, or in this case village, function and generate income. Due to proximity, this village was located near a junction city where markets flourish. Instead of introducing an agricultural programme that may be unfamiliar to some of these women, seeking out what they do best and employing a programme for those desires would be more beneficial to all parties involved.

Women's health and wellbeing in this region is improving, despite existing flaws in programmes set by the organisations. It is evident that an underlying factor in this progression is the promotion of gender equity and empowerment through such programmes.

These fundamental elements can allow for the possibility of social justice to prevail, as the foundation for the health and wellbeing of women in poor ruralities (Bull and Mittelmark, 2010). This was highly salient in the research done by other SDHVPR group members across three field visits on different continents, reported by Bull and Mittelmark (2010).

6.2 Salutogenesis

Salutogenesis is concerned with the relationship between health, stress and coping. The term, coined by Aaron Antonovsky (1979), a Professor of Medical Sociology, is described as an approach to focus on factors that support human health and wellbeing, rather than on factors that cause disease. Antonovsky claimed the way people view their life has a positive influence on their health (Antonovsky, 1979). He emphasised salutogenesis as not limited to one discipline but rather interdisciplinary (Lindström and Eriksson, 2006). It deals with more than just the person but the interaction between people and structures of society. Salutogenesis can be applied at an individual level, group and societal levels and fluctuates dynamically throughout life. (Lindström and Eriksson, 2006)

This theory explains why people despite stressful situations and hardships maintain wellbeing and happiness in the community. One paper based on research from this case study disclosed women's reported happiness correlate closely with survival and relationships (Bull, Duah-Owusu & Andvik, 2010). The data show a direct impact of social capital and women's health. Women were happier when husbands showed kindness and assisted them at home in addition to grown children's contribution with household responsibilities.

According to the salutogenic theory, 'general resistance resources' are material and psychosocial factors that make it easier for people to perceive their lives as consistent, structured and understandable. These include money, knowledge, experience, healthy behaviour, commitment, social support, culture, intelligence, traditions and view of life. If a person has access to these types of resources, there is a greater chance to deal with the challenges faced in life. They help the person to construct coherent life experiences. (Lindström and Eriksson, 2006) Antonovsky expresses that the crucial point is not what is available, rather the ability to use and reuse resources, both material and non-material, for the intended purpose.

The combination of a person able to assess and understand the situation they are in and the capacity to find a meaning and move in a health promoting direction using available resources is known as 'sense of coherence' (Lindström and Eriksson, 2005). To state it simply, three elements make up this sense of coherence: comprehensibility, meaningfulness and manageability.

This research revealed coping techniques by the women which the author had not expected. The women shared their experiences of illness and death. Interestingly most just accepted their situations of life and death. One responded with, 'God gives, God takes.' It just is what it is. This related to meaningfulness and comprehensibility, elements that make up a sense of coherence as part of the salutogenic theory. One key informant shared an instance where she became so frustrated with the system when a woman died in childbirth yet could have survived if the correct measures were taken. Amidst her frustrations, she realised that everyone else had accepted it as life's circumstance. No one blamed other people or the system. Another key informant discussed how friendships can help women cope, for example relationship troubles and even death of a child. The ability to confide in someone else allows for relief and comfort as well as advice on how to move forward, another way in which the women managed their situations.

Coping with situations may also be influenced by how much control, or manageability, women have in their own lives. It is a matter of taking ownership and doing something about it. Marmot (2003) emphasises social position and health correlate with control and social participation. His work focused primarily on social determinants in developed countries, yet findings from this research illustrate similar outcomes. Women who participated in the women's cooperatives showed higher levels of satisfaction with their life circumstances. Repeatedly, women expressed their accomplishments, how they now had the possibility to spend their wages on necessities and desires. With the aid of NEA empowering these women to choose their own path in life, the health and status of women has greatly increased.

Previous research demonstrates that Ghanaian women think and worry too much (Avotri, 1997; Avotri and Walters, 1999; 2001). Avotri and Walters (1999; 2001) claim there is too little research on psycho-social health of women whereas much of women's health focuses mainly on reproductive health, defining women in terms of their childbearing; however they do stress the focus on the threat to women's health from childbirth should never be dismissed.

Their research explains psycho-social health problems come from the women's social and marital circumstances, that many of the symptoms the experience—problems sleeping, frequent headaches, feeling unhappy or sad—were due to their relationships with husbands (Avotri and Walters, 2001). This case study did not search for specific psycho-social health problems. However in exploring social health determinants that influence women's health and status, results support similar health issues experienced by the women in the research done by Avotri and Walters. Findings in this study indicate most women live in stressful situations. Daily they struggle to feed their children, manage household responsibilities, care for ailing family members as well as maintain social relationships. Although stress may not be a term commonly used to describe their emotions, many women stated they worry a lot.

Salutogenesis is important to the field of health promotion because 'the health promoter, irrespective of her personal bent, is pressured to be concerned with the person' (Antonovsky, 1996, p. 14). As stated by Antonovsky, the way we look at a person in terms of health and disease is a moral one, and that a salutogenic approach, in contrast to a pathogenic approach, promotes a holistic view of people. Just as Avotri and Walters embraced a holistic approach in their research, this study on social health determinants too considered various facets of health and health determinants in order to better understand how women in poor ruralities thrive.

6.3 Globalisation

Globalisation not only impacts certain societies or people groups, it affects the entire world. This is especially evident nowadays as technological advancements expose people to what were once unfamiliar cultures and lifestyles as well as current newsworthy events around the world instantaneously. Globalisation has both positive and negative implications seeing that humans are faced with more possibilities to progress while at the same time threatened by outbreaks and spread of diseases. Furthermore, history reveals that globalisation tends to benefit the few elite while detrimental to those underprivileged.

Though given various definitions, globalisation can generally be described as the flow of information, goods, capital and people across political and economical boundaries (Daulaire 1999). It is not a new phenomenon as it has shaped the modern world in which we live in today. These global changes influence human societies creating new patterns of health and

disease and reshape the broad determinants of health (Gostin and Taylor, 2008). Countries are no longer able to defend these effects and must rely on one another for health security (Gostin and Taylor, 2008).

It was evident that globalisation has and continues to influence communities in the Bole district. Radio, television and films were mentioned by key informants as factors which have created new ambitions and change in family patterns towards individualistic societies. The use of mobile telephones and internet is more common among the educated; however with the rise of educated people in the region comes an increase in use of these modern technological tools. People are moving around the country (and world) more than ever before as they are exposed and adapting to different cultures and ways of life. This influences diversity as distinct cultural identities blend together.

During the mid 20th century, key players—World Health Organization, World Bank and other UN agencies—dominated the scene with funding schemes and goals to improve health for all people. There was a shift in the later part of the last century from bilateral to multilateral development agencies (Lancet, 2009). This has allowed for more participation at the community level, where the real focus is needed. Global health is still in need of improved governance—including coordination, priority setting, engaging stakeholders, evaluating and monitoring progress (Gostin, 2007)—as well as employing more holistic approaches for intended health programmes.

An underlying factor of NEA's success comes from their holistic approach while tackling health problems in the region. Their mission is an integrated approach as they try to consider all of the causes of poverty in their planning rather than focusing on a single sector, in addition to only starting programmes that are potentially sustainable (GRID-NEA, 2009). NEA has found that improving women's health depends on several factors: food security by improving the amount and the variety of food they have; sanitation by providing clean water and latrines; health education for families; environmental protection by eliminating toxins; while at the same time creating and maintaining a peaceful, stable environment for long-term development (GRID-NEA, 2009).

Although global health is improving, one failure has been the lack of progress on socioeconomic determinants of health, more specifically the neglect of health inequalities that

remain (Marmot, 2005; Beaglehole and Bonita, 2008). Reasons include the difficulty of intersectoral action, the narrow focus by developing agencies, foundations and politicians on short-term goals, and the lack of a strong global movement for improving health and inequities (Beaglehole and Bonita, 2008). The WHO's CSDH (2008) identifies ways of overcoming causes of health inequalities, including the need to improve daily living conditions and circumstance in which people are born, live, work and age. Evidence based approaches are necessary to measure and assess the effect of programmes as well as the willingness of international, national and local agencies to strengthen the social justice approach to health (Labonte and Schrecker, 2007; CSDH, 2008). However, as this study shows, measurement of such cannot be standardised for all societies worldwide.

Despite numerous failed attempts, there exist areas where evidence of globalisation through collaboration of NGOs and government funding has improved sustainable living conditions for people through achieved development programmes. Globalisation has certainly influenced the livelihood of women in this case study. The data revealed that NEA's intervention programmes improved women's capacity in an effort to fight against extreme poverty. Training and education programmes increased their human capital as well as financial and physical capital through the creation of income generating activities.

Conversely, these intervention programmes do expose negative aspects that should also be considered. Globalisation has permeated in the region having an effect on cultural capital, such as identities and lifestyles of the people. Social capital is also shifting as family dynamics are drastically changing, where multiple generations once lived together in one compound now only a single family unit resides. Individualism is on the rise and those most vulnerable, the elderly and widowed, are uncared for. Previous livelihoods of women are encroached on and replacement programmes have not been introduced. For instance, the ban of charcoal burning and selling has left many women out of work with nowhere to turn for financial capital. Though NEA has introduced women cooperatives, not everyone is able to participate. These effects on societies must be regarded by implementers of such interventions seeing that the betterment of the people is foremost.

Urbanisation is a global phenomenon changing the way urban dwellers live (McMichael, 1993; Riskin, 1994; Yusuf et al, 2001). Research in developing countries focuses on this as slums are on the rise affecting population health (Harpham and Stephens, 1991; Sclar et al,

2005; Riley et al, 2007). It is important to give attention to these rising health threats. However, this study, along with the entire SDHVPR project, recognises the need for more health research and development in poor ruralities as well.

Globalisation is inevitable as it has been for centuries. We cannot ignore this fact and let it drive those most vulnerable further into poverty. As stewards, we must continue to build on existing knowledge, through research and multilevel collaboration, to understand how we can utilise aspects of globalisation to allow all people the opportunity for a healthy life.

6.4 Methodological considerations

This part of the discussion will evaluate factors which may have influenced the validity and reliability of the results in the present thesis. In any scientific research, one must consider the authenticity of findings in the study. Certain threats, intentional or not, do exist to the validity and reliability of data. However in reporting the awareness of such, credibility can be achieved (Creswell, 2009).

6.4.1 The role of the researcher

This is the author's first qualitative research study therefore inexperience in the role as the researcher may have affected the outcome of the study. The author was aware of such concerns early on and made the effort to reduce these before initiating research. Having only minor previous knowledge in collecting qualitative data, guidance was sought from experienced researchers in the research group and at the research centre. In addition, the author read a great deal to give better insight on how to approach the interviews as well as what type of questions to ask. Data was collected with two other researchers which contributed to strengthening the quality of the process, though further experience could have improved the quality of the data even more. However, the data collected turned out to be rich and content was confirmed across data sources, between focus group interviews and key informants.

Being a white woman from a developed country to seek sensitive information of black women in a developing country may have hindered how the women revealed information during interviews. Thus the author attempted to present herself not as a threat but rather one of inquisition to understand how the women if these areas live and hopefully to one day better

their situation. It was made clear when the author and fellow researchers arrived at each village that they came not with empty promises to bring change or receive resources. Rather, it was explained that the women's participation could pave the way for future changes of poor rural women. The fact that the author and colleagues are women had its benefits as discussions of marriage and childrearing issues created a common understanding of each other.

Due to earlier living experiences and humanitarian work in West African countries, the author had previous knowledge on culture and lifestyle of Western African people groups. Being aware of this, those experiences were kept separate to the best of the author's ability to not let it taint the research. However, this did enrich probing techniques as the author was able to draw on existing information from personal experience, as well as advice on local customs given by NEA workers, to gain and understand the ways of the women specific to Northern Ghana.

6.4.2 Validity

Validity is the strength and soundness of a statement (Kvale, 2009) and the extent to which an account accurately represents the social phenomena to which it refers (Silverman, 2005). In order to maintain accuracy in the results, the author used certain procedures Creswell (2009) offers to ensure for qualitative validity and consistency. For instance, transcripts were verified so they contained no obvious mistakes during transcription, and repeated checking was performed for consistency in the meaning of codes used in the analysis and results.

Also considered were how certain aspects of this case study design might have deterred or enhanced validity. The author was present during all interviews, and worked closely with fellow research partners to make sure all were in agreement when implementing the interviews. Clear instructions were administered to each translator/transcriber to be as accurate as possible when translating questions and responses. With one of the researchers being Ghanaian, her knowledge of the language and presence during the interviews carried out in the local Ghanaian dialect helped to adhere to this. The translator who translated and transcribed the focus group interviews was not present during interviews to reduce any possible bias.

Only one week was spent in Bole district and more time could have been useful for re-interviewing. Unfortunately due to finances and short time frame, only one field trip was planned and budgeted. The author obtained contact information from key informants with the possibility for future contact should the need for follow up questions and clarifications arise.

6.4.3 Reliability

In qualitative methodology, reliability is the extent to which consistency and dependability appear evident in a study. Hammersley (1992) conveys reliability as 'the degree with which instances are assigned to the same category by different observers or by the same observer or by the same observer on different occasion.' In order to accomplish this there were certain methods utilised. For instance, documenting data collected was done in the same manner for each interview, whether focus group or key informant. An advantage to having three researchers doing the data collection together was the option to compare notes and observations.

It was important that questions were clear and understood in the same manner by the participants (Silverman, 2005). This was especially true since translators were used for the focus group interviews. It was crucial that the translators understood the meaning of the questions asked to then convey it in the local language for the women to comprehend. Of course, it is near impossible to do so completely but because the translators are fluent in both English and the local dialect it allowed for enough precision to analyse the data. Previous to interviewing, discussions were had with the NGO directors and translators about key concepts like 'health' and 'status' and 'happiness,' in relation to the study and how they could best be translated. Coming from outside the region, all three researchers, to the best of their ability, presented and maintained a neutrality to abstain from partiality.

6.4.4 Limitations

No matter how well the questions are developed, pretested and revised some respondents may have problems understanding a question; a topic may have been too sensitive; a respondent may have knowingly lied to protect a desired image; or afraid of negative consequences from truthful response (Mitchell, 1965). As a qualitative researcher it is wise to keep this in mind throughout the entire research process to eliminate as many limitations as possible.

There are several known limitations in this study. The translator may have unwittingly injected a bias or misinterpreted a response. There may have been details or significant statements lost due to the language barrier. The women may have felt pressure in answering because of the presence of staff (translators) from the local NGO. The respondents may have given responses that they presume the interviewer wished to hear. Nevertheless, common themes and responses are evident from all focus group interviews and key informants to strengthen results.

Generalizability is “the extent that findings in one situation can be transferred to other situations” (Kvale and Brinkmann, 2009, p 324). This research is specific to a group of people in a particular district of Northern Ghana and therefore it may be difficult to use the data from this study and apply it to other settings, or people groups. Fewer than a hundred people were interviewed, including the pilot test, therefore these findings alone are insufficient to generalise to the entire population. However, other research within the SDHVPR project includes qualitative research from Haiti, India, Tanzania, the Philippines and Canada. Commonalities may arise from these studies allowing for further research to strengthen findings of poor ruralities in developing countries.

7.0 Conclusions

There is growing research on social determinants of health in poor ruralities as people begin to recognise the significance in utilising various tools for measuring health determinants within and not just between nations. This study provides new insight on which determinants might be considered when measuring for women's health and status at childbearing age in extremely poor regions. However, there is still the need for more research in this arena to contribute to a basis of knowledge as the research topic is still fairly new.

The data from this study indicate women can and do thrive in harsh living conditions. Although most women were not completely healthy, as defined by the WHO in the first chapter, women were able to sustain livelihoods to support themselves and their families. Unfortunately, the challenge lies in creating these opportunities because the women live in such dire circumstances. They have little access to existing resources in order to start on their own. Assistance from local organisations and agencies is required to create activities for them. According to the capitals within the SL framework, it is possible for a woman to thrive if she has attainable resources. In the Bole District, human capital such as skills training and basic education were important factors for a woman to succeed in an income generating activity. Social networks, including assistance from husbands and children, were also suggested as important for women's prosperity. It was difficult for a woman to succeed on her own, meaning social support had significant contributions to women's health and status. Further research may shed new light on which health determinants in the context of social relations may increase women's health and status the most.

More research is needed on the collaboration between local organisations and governments to provide better access to healthcare. This study indicated an immense need for health education for the people living in these communities. It was unclear from this study how effective current health education programmes are. However, data from this study do confirm that it is insufficient for health to progress. Perhaps it would be interesting to conduct such research in the area to learn how to effectively implement health programmes for women as well as men and children. This would include family planning as well as training health personnel living within the remote villages.

The CSDH (2008) discloses rural poverty and health have unique features that differentiate it from urban poverty and health. This study confirms that and also reveals a need for developing distinct measuring tools for socioeconomic status and health status of people residing in poor ruralities. Health-improving practice must be based on evidence from research, therefore and in conclusion, targeted research on the SDH in poor ruralities is essential alongside research on urban poverty and health in order to reduce existing health inequities within and between nations.

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9.0 Appendices

9.1 Appendix I

The following interview guide was prepared before the field visit and was used together with a textile picture of two Ghanaian women with their families in a village setting. After piloting this guide, we decided to switch to an approach including less comparison and abstract thinking.

"Today we are going to talk about two women. In many ways these women are similar. They are both married. They both have three children each. Here you see their husbands and children in the background. None of the households are richer than the other. They live in the same village. They drink water from the same source, the families are just as poor or rich. But the women do not feel the same. This woman says she feels strong and full of energy. This other woman is feeling weak, and ill.

- This woman says she feels strong and full of energy.
    - Do you think many women in your village feel like her?
    - This lady, do you think she has just been lucky or has she worked hard for it?
        - Check for ancestors, faith etc
    - Why do you think this lady is feeling strong and full of energy?
- This woman says she feels tired and ill.
    - Do you think many women in your village feel like her?
    - What would you guess are the health problems of this lady, if she is an ordinary woman from you village?
        - Illness and death vs. worry and thinking too much?
    - What would you guess has made her weak and ill?
- What could make the one woman strong and the other weak/ill when they
    - Live in the same village
    - Drink from the same water source
    - Are both married?
- What is a good life like for a woman who lives in the villages in this area?
- What is important to have a good life as a woman?
    - What gives you joy in life?
- What do you think women in your village dream of?
- Describe the husband of the strong woman
    - How are husbands chosen for a woman?
        - Woman self, family?
    - How would choice of partner influence her happiness and health?
        - Evt if equal upbringing/culture of wife and husband is important
    - How does he behave that helps her feel strong and happy?
    - How are decisions made in the households?
        - If you make some money, can you decide how to spend it?
    - If you see another family in the village, how could you see if the man respects his wife or not?

    - If this man has another wife, which difference would that make for this woman?
        - Would it be best to be the first or the second wife?
        - In which ways?
            - Power and popularity
- Find differences to the husband of the weak woman
- How do you think the family of the strong woman could be described?
    - What about the children could make the mother happy?
    - How could having children disturb the health of the mother?
        - Gender, age, number?
- Find differences to the family of the weak wife
- This woman is respected in her village. What has made the village respect her?
- How would you know that a woman is respected in her village?
- Is a woman happier and healthier if she is respected in her village?
    - Why?
    - If women could decide in the villages, which kind of things would a woman influence?
- Is it important for a woman that her husband is respected in the village?
    - Why?
    - How would that influence her health?
    - How could you tell that her husband is respected in the village?"

9.2 Appendix II

This is the interview guide we finally used as a basis for the focus group interviews in the villages:

- Children/husband/widowed
- Groundnut programme – tell us what it means for you to take part in it.
    - Money? Respect? Feeling?
- Starting the day. Feeling?
- Continuing the day. Evening – feeling?
    - Tiredness? Worry? What motivates?
- Tell me about your husband. Good? Why?
    - Help? How shows he cares? How can a husband help a wife be healthy?
- What is it like to be a widow?
    - Help and support?
- Child death. How does it make you feel when you loose a child? Anything you know of that could have prevented your child from dying?
- Childbirth – how does it influence your health?
- Need help – who goes to? Important? Why? Friends? Good times together? How feel?
- Any women in village shut out? Why?
- Know any really healthy women? Why healthy?
- Own health. Needed treatment? Illness or tiredness worst?
- Dreams and wishes for life
- When are you happy?

9.3 Appendix III

(Excerpt from: Bull and Mittelmark, 2010)

Northern Empowerment Association

The early version of Northern Empowerment Association was formed in the late 1970s by a group of young students who had grown up in the poor ruralities of Northern Region. Having experienced the hardships firsthand, they decided to dedicate their lives to relieving the sufferings of their own people, contributing their own knowledge and efforts towards development of the local rural areas.

Today NEA is a successful development organisation which has served as a model for other development organizations on the African continent. NEA has a strong link to Canada, as contacts were established when NEA initiator and director Dr. David Mensah studied for his PhD at the University of Toronto. In Canada he also met his future wife, Brenda, who has now been living in Ghana for a couple of decades working with NEA. A private support foundation in Canada contributes to the funding of NEA activities, and the funds NEA manages to raise this way are matched by the governmental Canadian International Development Agency, CIDA. In a 2009 evaluation after a CIDA visit to the NEA projects in Bole District, the organisation was given a top evaluation and graded 'excellent'. The aim of NEA is to be self-funded through sustainable activities, and there is progress towards this goal. After establishing activities in a certain geographic area, sustainability of the activities is ensured and NEA withdraws to develop new areas.

NEA has activities in the following sectors: nutrition, water, sanitation, education, health care, income generation, sustainable environment, and peace work. The primary objective is to strengthen the position of women, as women are found to be the most vulnerable:

"Anywhere where you go there is poverty, the women and children are hard hit I think, it is a well known factor that women and children normally suffer more." (David Mensah)

The NEA women's co-operatives

To support women, villagers are asked to identify the neediest women in the village. These are often widows or divorced, have husbands with health problems, or are vulnerable in other ways. Selected women are invited to take part in the groundnut programme which runs over three years. They are organized in groups of approximately 20 women in each village, under a local female leader. The first year the women are given a plot of land each and a bag of groundnuts to sow. In addition they receive support to plough the land, and agricultural training.

After harvesting each woman pays one bag of groundnuts back to NEA and thus enable another woman to join the programme. If the climate conditions are benevolent, they may have built up enough resources over their three years to continue farming on their own. As droughts have been reported as a problem for the women in the programme, NEA has, on request from the women, added the gift of a goat to the programme. This gift is received at the examination from the programme, after three years, and serves as a 'savings account' to carry the women through poor seasons.