



IUHPE

Research Report Series

**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**

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Table of Contents

Acknowledgements	p. 3
1. Project background	p. 4
2. Summary of findings	p. 18
3. The Ghana Reference Group Meeting, August 2008	p. 31
4. The India Field Visit, April, 2009	p. 49
5. The Ghana Field Visit, April 2009	p. 82
6. The Haiti Field Visit, May 2009	p. 127

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Chapter 1 Project background

Maurice B. Mittelmark

Women living in poorest rural areas in the Global South are among those in the world facing the largest potentially avoidable risk for early illness, disability and death. Still, some women in very poor areas fare much better, health-wise, than other women living in the same areas. Identification of factors that protect the health of women of childbearing age is a priority in the UN Millennium Development Goals. This is challenging, because the classic protective factors - higher income, higher education and higher occupational status - are poorly associated with health in very poor rural areas. In very poor regions, a household's livelihood is rarely supported by one or two steady monetary incomes, but rather by a range of activities undertaken by all household members, and in which barter, trade and subsistence agriculture are more important sources of support than cash salaries. Standard income and occupation classification schemes used in most public health research cannot capture such diversity. In such places, many, if not the majority of people have no education or only incomplete primary education, so standard education measures are inadequate.

Even if the classical living conditions and social position indicators are irrelevant in very poor areas in the Global South, it is reasonable to assume that living conditions and social position do determine health, at least in part. Thus there is a need for research to identify indicators of living conditions and social position that have relevance in such areas.

The aim of this project was to identify indicators of living conditions and social position amongst women of child-bearing age in very poor ruralities. Field visits were undertaken in rural communities in India, Haiti and Ghana, where expert Reference Groups were consulted, key informant interviews were conducted, focus group discussions were held, and observations were made. Chapter 3 presents the results of a preliminary consultation with a Ghana Reference Group in 2008, which helped prepare the field visits.

It was understood from the beginning that the specific Indian, Haitian and Ghanaian contexts of this study are unique, and it is likely that many aspects of living conditions and social position are specific to particular contexts. We wished to document the heterogeneity, but we also hoped to identify a few aspects of living conditions and determinants of social position that are ubiquitous across the contexts.

The report makes suggestions, summarised in Chapter 2, for aspects of living conditions and determinants of social position that might be measured in survey research and in surveillance systems so that the social determinants of health (SDH) relevant in very poor ruralities can be monitored and used in public health work. We emphasise that the suggestions in the summary chapter are just that – suggestions – since we have not yet undertaken empirical work in which we have observed ties between living conditions, social position and women's health. Thus this study is exploratory, meant as a stepping stone to further work in research programme *Social Determinants of Health in Very Poor Ruralities*.

The current project combines qualitative and quantitative analyses from countries across four continents. In this report we present the results from the initial phase of the project, in which qualitative data were gathered in rural areas of India, Haiti and Ghana

This report concludes work undertaken with funding from the Department of Health, England, for the International Union for Health Promotion and Education (IUHPE), which is the sponsoring agency. This project contributes to the work plan of the IUHPE's Working Group on the Social Determinants of Health.

In the second phase of the project, now ongoing, a mixed methods research approach is being used. Further qualitative studies are underway, springing from the findings and experiences of the initial exploratory studies reported here. Reports will be available in fall 2010 from qualitative research projects in Canada, Tanzania, Ghana, and The Philippines, and from quantitative projects in Ghana and Peru. Publications of further quantitative studies in Ghana and elsewhere are scheduled starting fall, 2010, utilising data collected in Demographic and Health Surveys. Following from the success of the initial phase of the project, a Thematic Cluster on the Social Determinants of Health has been established at the Department of Health Promotion and Development, University of Bergen, to ensure the steady recruitment of master's and doctoral students to this important research arena.

Social Determinants of Health

The usual approach used in the study of the SDH (hereafter referred to as the Standard Model) has these seven characteristics:

- The health outcomes are usually morbidity and mortality due to chronic diseases. Mental health and well-being are starting to receive some attention.

- The proximal determinants of greatest interest are usually behavioural, including lifestyle choices (e.g., eating, drinking, inhaling, moving). In much of the epidemiological research, such risk factors are the primary interest and SDH are controlled for statistically.
- The social determinants indicators of greatest interest are education, income and employment, or some combination used to classify people into social classes, also referred to as social position. These measures are preferred because one or more are commonly available in epidemiological studies and population health surveillance registries.
- The research takes place mostly in industrialised countries.
- The research paradigm is quantitative and the observed associations between social position and health are statistical.
- The populations included in the research are usually working age adults; children, the elderly and vulnerable sub-groups (e.g., the ill, the homeless; the unemployed) are rarely included. Women are underrepresented. Recently, women, children and adolescents have received more attention.
- The analyses are mostly at the large area level, such as country-level international comparisons, interregional comparisons within countries, and aggregate urban/rural comparisons.

The Standard Model has good utility in social epidemiology. Data and analyses that have been generated using the Standard Model show convincingly that at a collective level, the socio-economic (SES) circumstances in which people live influences their health (Marmot and Wilkenson, 1999; Berkman and Kawachi, 2000; Smith, 2003). Those classified as having higher education, income and high status employment have better health than those classified as having lower levels of education, income and lower prestige employment. This is observed along the entire gradient of SES. There is evidence that the relationship is reciprocal, that health affects SES and that SES affects health (Smith, 2004).

Two main explanations for this pattern vie for attention, but both are credible (Dunn, et al., 2006; Marmot and Wilkinson, 2001). One explanation is that SES determines the material conditions of

living, and that those with higher SES have access to a host of material goods, facilities and services that support good health (Lynch, et al., 2000). The poor lack material resources to the point that their health may suffer, and the poor may be more susceptible to ill health than the wealthy (Davies, 1997). This viewpoint is less concerned with explaining the SES/health gradient at all its points than with explaining why very poor people have poor health.

The main alternative viewpoint is that in addition to material circumstances, there are psychosocial effects of relative deprivation, such that even people with relatively good material circumstances may experience poorer health than people who are better off (Marmot and Wilkinson, 2001; Siegrist and Marmot, 2004). As Marmot (2003) has put it, “The social gradient in health is influenced by such factors as social position; relative versus absolute deprivation; and control and social participation” (page S9).

Research in this arena is burgeoning and a relatively recent development is a life course approach to the study of SDH (Kuh and Ben-Shlomo, 1997). This calls for the use of a much wider array of SES indicators and health endpoints than is typical in the Standard Model (Braveman, et al., 2005). For example, Pollack and colleagues’ (2007) systematic review of wealth as an additional indicator to those of the Standard Model suggest that failure to measure wealth may seriously result in under-estimation of the SES-health relationship. Different indicators may have significance at different stages of the life course. For example, the indicators relevant for child health are parents’ income, education and occupation, while the indicators relevant for the health of adults is their own income, education and occupation (Galobardes, et al., 2006). In fact the Standard Model is rapidly fading into its proper historical context with regard to its SDH indicators, its focus on working age adults in industrialised countries, and its focus on chronic diseases.

Today, it is widely appreciated that the causal web linking social determinants and health is extraordinarily complex, encompassing not only a life course dimension, but also political, economic and cultural dimensions, all interacting in a systems-like manner. This complexity is emphasised in Figure 3.

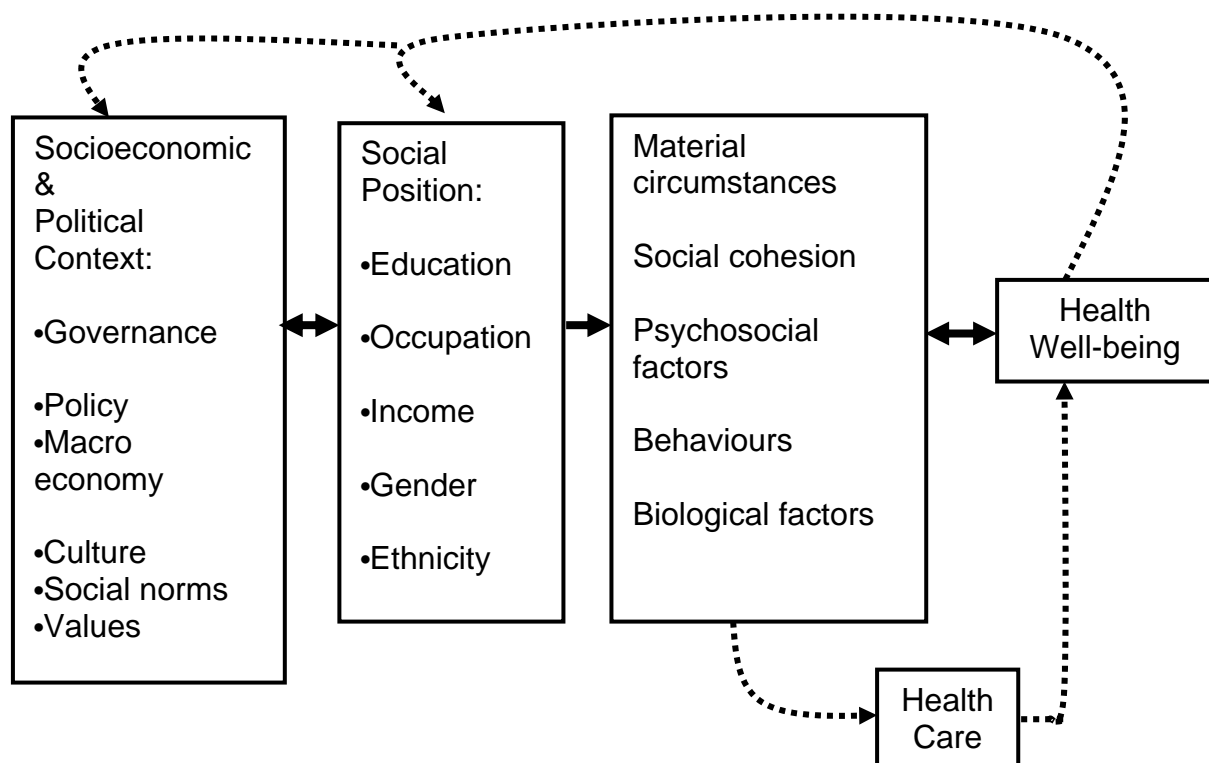


Figure 3. Social determinants of health, conceptual framework adapted from CSDH (2008), Figure 4.1, page 43.

This understanding of the SDH suggests many entry points for action to reduce health inequity. It also suggests that surveillance and monitoring systems and survey research require a great deal more data on a much wider range of variables than has been typical in research guided by the Standard Model. Accordingly, the Commission on Social Determinants of Health's recommendations to countries call for expanded monitoring to include living conditions, health behaviours, physical and social environment, working conditions, health care, social protection, gender, social inequalities and socio-political context (CSDH, 2008). A minimum national surveillance system is also specified, including gender, at least two social markers (amongst education, income, wealth, occupational class, ethnicity/race), and at least one regional marker (e.g., rural/urban, province). However it is clear that while such a minimal system is better than nothing, it is inadequate.

The Global South

The Standard Model and the life course model have guided research mostly in the industrialised countries of the northern hemisphere. When countries of the Global South have been included in analyses, these have mostly been ecological studies of the relationship between national level SES indicators and health. Importantly, the Commission on the Social Determinants of Health have taken

a decidedly global perspective, emphasising the need for action that is appropriate to the varying situations in urban and rural places in various parts of the world (CSDH, 2008, Chapter 6). This focuses greater attention on the SDH in the Global South than has heretofore been usual.

There is a dearth of information about the SDH and about health in the Global South. Basic national health information systems are yet to be established in many countries (CSDH, 2008, page 178).

Without valid and reliable birth and death registries, the basic health information needed for policy-making and research is not available. Surveillance is needed in the SDH, but a prior need is research to identify what the key SDH are. The SDH of the Standard Model have little relevance in many areas in the Global South, as taken up in some detail below.

Besides chronic diseases, infectious diseases and accident and injury are of great public health significance in the Global South generally, and in its poorest urban and rural areas in particular. Also of major importance is the precarious existence of many families living with one or more of the following chronic stressors: war and lawlessness, drought, flood and famine, an almost total absence of educational opportunities, lack of health and welfare services, lack of clean water and enough food, poor shelter, and the struggle to make a minimal livelihood.

Very Poor Ruralities in the Global South

Migration from countryside to city is a global phenomenon. In the Global South it is often a family livelihood strategy, with some members going to the city for work and providing income to the family in the countryside. For most labour migrants, it is a matter of moving from rural to urban poverty, with many returning to rural poverty when their productive years are behind. Today policy-makers are focussed on the urban poor, because their numbers are growing and because large slums in cities demand attention in a way the dispersed poverty in the countryside does not (Riskin, 1994). Yet as the Commission on the Social Determinants of Health points out, rural poverty/health has unique features that distinguish it from urban poverty/health (CSDH, 2008, pages 69-71). Therefore targeted research on the SDH in poor ruralities is needed, alongside research on urban poverty/health.

The shortcomings of using the Standard Model's SDH indicators in poor ruralities are obvious. In very poor ruralities, many individuals do not have a single main occupation. They engage in many livelihood-generating activities, moving from one to another as the day progresses, as seasons change and as opportunities come and go. The range of available education for most people living in very poor ruralities is not from pre-school through graduate school, but is usually nothing to a few years of grade school. Cash income is not the main source of livelihood, rather labour exchange,

barter and trade, borrowing and subsistence farming and husbandry are the sources of livelihood for many.

It is widely recognised that SDH measures that are suitable in rich places may not be suitable in poor places, rural as well as urban. For example, the United Nations uses two human poverty indexes, one for use with developing countries and another for use with OECD countries (UNDP, 2007).

Small Area Analysis

It is an ecological fallacy that national characterisations regarding wealth and health can be projected to smaller areas within countries. This is illustrated by data from Indian states on the prevalence of underweight among preschool children. In the 2005-6 NFHS-3 survey, the highest prevalence was 60.3 percent in Madhya Pradesh and the lowest prevalence was 21.6 percent in Mizoram (Antony and Laxmaiah, 2008). Prevalence rates would be seriously miss-estimated in both these regions were the national average of 45.9 percent to be used. Also, national and international level SDH studies cannot provide the detail needed to support intervention in small areas. The SDH and health vary from city to countryside, from arid plain to lush savannah, and from mountain to coast. Solutions to health problems are not necessarily the same in all places.

Even analysis at the state level may be too crude. Gwatkin (2005) remarks “...it might seem reasonable to expect any disparities within a small geographic area to be modest, especially compared with those reported for the country where the area is located...However [...] such is by no means always the case, at least with respect to equity’s economic dimension.” (ibid, page185). A study by Schellenberg and colleagues (2004) in very poor rural districts in southern Tanzania illustrates the point well. In these districts the means of making a livelihood is primarily subsistence farming and the SDH in the Standard Model are irrelevant. The researchers composed a measure combining information on these resources/assets: having a tin roof, the head of household having some non-farm income, ownership of mosquito nets, ownership of a bicycle or radio, renting a house, and the child carer having some non-farm income. The measure was used to classify households where the children resided into quintiles, from most poor to least poor. Care-seeking for a wide range of childhood maladies varied consistently with the SES measure. There were also graded relationships between SES and morbidity and admission to hospital, accessibility to health care facilities, care management and compliance with care regimen. The authors conclude:

“In a very poor area of rural Tanzania, with high morbidity and mortality rates, our results suggest that the main difference between the poorest children and those who are better off is not in the likelihood of falling ill, but in the probability of obtaining suitable treatment once ill. Carers of children from wealthier families had better knowledge about danger signs, were more likely to bring their children to a health facility when ill, and were

more likely to have had a shorter journey to the health facility than poorer families. Their children were more likely to have received antimalarials and antibiotics for pneumonia, and were more frequently admitted to a hospital.” (page 5).

Poverty

The face of poverty is different in different places. In a market economy where money is the usual medium through which material and neo-material goods are acquired, living in poverty in its classical meaning is not having enough money for the level of subsistence and level of privilege considered basic by society. In places with little attachment to money-driven markets, such as subsistence agriculture communities, poverty means having a low level of access to the means of production (e.g., land, animals, implements), low levels of production and experiencing ‘subsistence on a precarious level’ (Kosa, 1969).

In all places, the concept of poverty is useful to indicate a troubled place on a complex continuum from being terribly poor to being extraordinarily wealthy. However the nature of that troubled place varies tremendously with differences in context. In a Western European country, having an income below a certain level is a useful way to define poverty and qualify the impoverished for welfare assistance. In Mozambique, people’s own descriptions of what it means to be at various places on the poor-wealthy continuum illustrate the very limited applicability of the income-poverty concept in certain parts of the world (Tvedten, et al., 2006):

- ‘Ohawa’ The deserving poor, suffering misfortune and poverty due to the inability to work and isolation. A condition of the old, the sick, widows/widowers, orphans, the disabled
- ‘Ohikalano’ The deserving poor, due to misfortune, poverty due to the inability to make an adequate livelihood. A condition of younger people unable to produce, but not through their own fault; caused by loss of land, drought, flood, poor return on labour
- ‘Opitanha’ The deserving poor, the victims of calamities caused by others or by events, trapped by their own failed attempts to cope, and can’t be assisted. A condition of people without relatives
- ‘Ovelavela’ The undeserving poor, entrapped due to their own behaviour. A condition mostly of single young men who do not exert enough effort, and who have failed to maintain good social relations

- 'Wihacha' The undeserving poor, causing their own suffering. A condition mostly of young adults who do not follow advice, are lazy, with drinking/drug/adultery problems, and who bring shame to their families
- 'Okalano' Those who have deserved wealth based on hard work. A condition of people with good agricultural production and money, who learn well and put learning into practice, successful in all they do
- 'Opwalatha' Those with wealth partly due to birth and luck, partly due to hard work. A condition of people who having 'everything and can give work to others
- 'Orela' Those with wealth largely due to luck, possibly witchcraft. A condition of those who produce a lot, who know how to make good use of resources, lucky people who get support and have money to invest

Poor-wealthy constructs such as these contain reference to material circumstances, as do the classification schemes used in SDH research, but they also contain reference to gender, age, external influences and resources, behaviour and the spirit world. While illustrating subtleties in the way SES may be understood by various cultures, there remains the problem that for research purposes, such classifications suffer the same limitation as does income as a SDH indicator. They are useful in specific contexts, but may be less useful in making comparisons across contexts.

In SDH research, poverty and wealth are treated primarily as properties of individuals, but also as properties of districts. It is common in intra-country analyses to rank districts/states/provinces on some measure of poverty/wealth and undertake district level analyses of the relationship of wealth to health. Treating whole populations in this way, as though there is no important variation within a population, masks the fact that within any group of people, "means and privileges are unequally distributed, and there is a class which possesses both and another class which is deficient in both (Kosa, 1969, page 4).

At the small area level within countries, health is variable and so are its determinants. For example, while income is a good SDH indicator in London in the UK, it is a poor indicator in the FilaBavi region in Vietnam. However material wealth is a good SDH indicator in the FilaBavi region, where the mortality rate amongst 15-59 year olds is 3.5 times higher in the bottom fifth of material wealth compared to the top fifth (Indepth Network, 2005, page 198).

While mainstream researchers in the SDH arena have not devoted themselves to small area analyses, or to very poor rural areas, some health researchers, and especially development researchers, have developed methodologies suitable to small areas that are very poor by the standards of the regions/nations within which they are situated. Indicators that have good utility in such places include expenditure measures, material wealth measures and livelihood measures, along with measures of physical, natural, human, social, cultural and political capital,

The use of the capital concept is somewhat controversial, and has been much discussed in the literature. Some object to a too-loose use of the capital construct, which in its classical sense refers to land, labour and financial resources that require investment. However the investment aspect of 'raising and spending capital' is also central in the original formulation of the venerable social capital construct of Bourdieu (1985). Writing about Bourdieu's social capital, Portes notes "Social networks are not a natural given and must be constructed through investment strategies oriented to the institutionalization of group relations, usable as a reliable source of other benefits." (page 3).

Others object on political grounds. As a prominent example, Navarro (2004), writing about social capital, does not

"...feel comfortable with that concept or with the terms used to define it. [...] In the U.S. context ... social capital is commonly used as a measure of the richness of civil society, presented (erroneously, we believe) as an alternative to public society. We disagree with this interpretation of social capital. Our understanding does not assume a zero-sum situation – that is, that the larger the one form of society, the smaller must be the other." (pages 3-4).

Some prefer the terms 'assets' or 'resources' to capital, or social cohesion rather than social capital, to avoid the 'market' connotation of capital. However capital's investment dimension does have importance in the SDH context. Whatever it is called, human capital including education requires investment; social capital including social networks requires investment. It is in this sense -- that people and communities can develop these capitals through their own investment -- that the capital construct has salience in considering the SDH in very poor ruralities.

In the following Chapter, the results of the empirical work undertaken in this project are summarised, using a capitals framework. The details of the fieldwork that is the basis of the summary are presented in the last three Chapters.

References

- Addison, T., Harper, C., Prowse, M., Shepherd, A. The Chronic Povert Report, 2008-09. Escaping Poverty Traps. Chronic Poverty Research Centre, The University of Manchester.
- Alkire S. Valuing Freedoms. Sen's Capability Approach and Poverty Reduction. Oxford, Oxford University press, 2005.
- Antony, G.M., Laxmaiah, A. Human development, poverty, health and nutrition situation in India. Indian Journal of medical Research, 2008;128:198-205.
- Berkman, L.F., Kawachi, I. (eds.) Social Epidemiology, 2000, Oxford, Oxford University Press.
- Braveman, P.A., Cubbin, C., Egerter, S., Chideya, S., Marchi, K.S., Metzler, M., Posner, S. Socioeconomic status in health research. One size does not fit all. JAMA, 2005;294(22)2879-2888.
- Bourdieu P. The forms of capital. In J. G. Richardson (ed.) Handbook of Theory and Research for the Sociology of Education, New York, Greenwood, 1985:241-258.
- Brunner E., Marmot, M. Social organization, stress, and health. In: M. Marmot and R.G. Wilkinson (eds.) Social Determinants of Health, Oxford, Oxford University Press, 1999: 17-43.
- Calderwood, P.E. Toward a professional community for social justice. Journal of Transformative Education, 2003;1(4):301-320.
- CSDH. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. 2008, Geneva, World Health Organization.
- Dunn, J.R., Veenstra, G., Ross, N. Psychosocial and neo-material dimensions of SES and health revisited: Predictors of self-rated health in a Canadian national survey. Social Science and Medicine, 2006;62;1465-1473.
- Filmer, D., Pritchett, L. Estimating wealth effects without expenditure data—or tears: An application to educational enrollments in states of India. Demography, 2001;38(1):115-132.

Galobardes, B., Shaw, M., Lawlor, D., Lynch, J.W., Smith, G.D. Indicators of socioeconomic position (part 1). *Journal of Epidemiology and Community Health*, 2009;60:7.12.

Gwatkin, D.R. Assessing economic inequalities in health. Contributions of the INDEPTH Health Equity Project. In: Indepth Network (eds) *Measuring Health Equity in Small Areas*. Burlington, Vermont, Ashgate Publishing Company.

Gwatkin, D. Rustein, S. Johnson, K. Pande, R. Wagstaff, A. *Socio-Economic Differences in Health, Nutrition and Population*. Washington, 2000, D.C., The World Bank.

Indepth Network. *Measuring Health Equity in Small Areas*. Burlington, Vermont, Ashgate Publishing Company.

Johnson, K., Bradley, S.E.K. Trends in Economic Differentials in Population and Health Outcomes: Further Analysis of the 2006 Nepal Demographic and Health Survey, 2008, Calverton, Maryland, USA, Macro International Inc.

Kosa, J. The nature of poverty. In: J. Kosa, A. Antonovsky, I.K. Zola (eds.) *Poverty and Health. A Sociological Analysis*, 1969,. Cambridge, Mass., Harvard University Press.

Kuh D., Power C., Blane D., Bartley M. Social pathways between childhood and adult health. In: D Kuh and Y Ben-Shlomo (eds) *A Life Course Approach to Chronic Disease Epidemiology*. Oxford, Oxford University Press, 1997:169-198.

D Kuh and Y Ben-Shlomo (eds) *A Life Course Approach to Chronic Disease Epidemiology*. Oxford, Oxford University Press, 1997:169-198.

Kuklys, W. Amarta Sen's Capability Approach. *Theoretical Insights and Empirical Applications*. Berlin, Springer-Verlag.

Lynch, J.W., Smith, G.D., Kaplan, G.A., House, J.S. Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions, 2000;320:1200-1204.

Marmot, M., Wilkenson, R.G. *Social Determinants of Health*. Oxford, Oxford University Press, 1999.

Marmot, M.G. Understanding social inequalities in health. *Perspectives in Biology and Medicine*, 2003;46(3):S9-S23.

Marmot, M., Wilkinson, R.G. Psychosocial and material pathways in the relation between income and health: a response to Lynch et al. *BMJ*, 2001;322:1233-1236.

Mwageni, E., Masanja, H., Juma, Z., Mumburi, D., Mkilindi, Y., Mbuya, C., Kasale, H., Reid, G., de Savigny, D. Socioeconomic status and health inequalities in rural Tanzania: Evidence from the Rufiji Demographic Surveillance System. In: Indepth Network (eds) *Measuring Health Equity in Small Areas*. Burlington, Vermont, Ashgate Publishing Company.

Navarro, V. Introduction: Objectives and purpose of the study. In: Navarro, V. (ed.) *The Political and Social Context of Health*. New York, Baywood Publishing Company, 2004.

Pollack, C.E., Chideya, S., Cubbin, C., Williams, B., Dekker, M., Braveman, P. Should health studies measure wealth? A systematic review. *American Journal of Preventive Medicine*, 2007;33(3):250-264.

Portes, A. SOCIAL CAPITAL: Its origins and application in modern sociology. *Annual Review of Sociology*, 1998;24:1-24.

Riskin, C. Chinese rural poverty: Marginalized or dispersed? *The American Economic Review*, 1994;82(2):281-284.

Siegrist, J., Marmot, M. Health inequalities and the psychosocial environment – two scientific challenges. *Social Science and Medicine*, 2004;58:1463-1473.

Sen, A. *Inequality Reexamined*. Cambridge, Harvard University Press, 1992.

Sen, A. *Development as Freedom*. New York, Anchor Books, 1999.

Schellenberg, J.A., Victoria, C.G., de Savigny, D., Schellengerb, D., Mshinda, H., Bryce, J., for the Tanzania IMCI MCE baseline household survey study group. Inequities among the very poor: health care for children in rural southern Tanzania. *The Lancet*, 2004;261:561-566.

Smith, G.D. (ed) Health Inequities: Lifecourse Approaches. Bristol, 2003, The Policy Press.

Smith, J.P. Unraveling the SES-Health Connection. In: Waite, L.J. (ed.). Aging, Health, and Public Policy: Demographic and Economic Perspectives. Supplement to Population and Development Review, 2004;30. Reprinted by Population Council, New York, USA.

Smith, G.D., Socioeconomic differentials. In: D Kuh and Y Ben-Shlomo (eds) A Life Course Approach to Chronic Disease Epidemiology. Oxford, Oxford University Press, 1997:242-273.

Smith, G.D., Shipley, M.J., Rose, G. Magnitude and causes of socioeconomic differentials in mortality: Further evidence from the Whitehall Study. Journal of Epidemiology and Community Health, 1999;53:265-270.

Tvedten, I., Paulo, M. and Rosário, C. Opitanha: Social Relations of Rural Poverty in Northern Mozambique'. CMI Report 2006: 16. Bergen, Norway: Chr. Michelsen Institute. Available at: <http://www.cmi.no/pdf/?file=/publications/2006/rep/r2006-16.pdf>

UNDP. Human Development Report 2007/2008. 2007, New York, Palgrave Mcmillian.**Chapter 1.**

Torill Bull

This Chapter summarises observations made during brief field visits to poor rural areas in India, Haiti, and Ghana, all in 2009, the details of which are reported in later Chapters. These visits were preceded by a consultation in Bergen in 2008, reported in Chapter 3, outcomes of which are also included in this summary. The project uses a ‘capitals’ framework to organise much of the analysis.

Here, we do not suggest specific living condition indicators for use in research in very poor ruralities. Rather, we try to illuminate aspects of social life and daily living which may impact on women’s health, in places where the standard indicators of living conditions – income, education and occupation -- are inadequate. We do intend to develop and test living conditions indicators for use in survey research, but that is work for the future, to be based on the work of the present. We hope that the reader will be sensitised to the need for new thinking about how to measure living conditions in places that are a galaxy away from Western societies, where most of the research on the social determinants of health and living conditions indicators is conducted.

Financial and material capital

Having her own income increases a woman’s resources in many ways. In addition to the obvious contribution to livelihood and survival, it increases status, it can improve the husband and wife relationship, and it gives the woman increased independence. Ownership of very specific items can make a great difference to a person’s chances of making a livelihood. This is exemplified by the Ghanaian woman who secured her livelihood after being able to buy a pot in which to brew local beer; the benefits cascaded, as when her son was able to start a goat herd with some of the proceeds from her beer business. Which items are important will vary from locality to locality. Presence of and participation in various women’s groups (social capital) increases the financial security of many women in poor ruralities, illustrating interaction amongst the various types of capital.

Physical capital

For health care to be really accessible, there are several factors that need to be in place. First, distance is obviously important. Independently of distance, there must exist reasonable alternatives for transport. In a village in Ghana, when complications arose during child birth, the only option for taking the woman in labour to a health care facility was to transport her on the back of a bicycle.

Even if the health care facility is physically accessible, prices can be a hindrance. Often problems with paying fees can lead to delays in health care seeking, with tragic consequences. An additional element that must be in place is the cultural appropriateness of health care, for instance the availability of female health personnel, and of respectful communication and treatment.

Distance to the nearest market can be of importance for several reasons. If you have a few coins to spend, you might have the impossible choice of spending them on transportation to the market if the distance is long, leaving nothing to buy food for and thus making the whole project moot.

Alternatively you could walk, thus spending extremely valuable time that could have been spent at productive activities, thereby increasing time poverty and contributing to general poverty.

Availability of sanitary facilities makes a great difference in the cleanliness of the community surroundings, reducing the spread of infections and contamination. The reduction in time and effort spent to collect water for household usage can make a great difference in the strain of daily living for women. Boreholes and wells not only reduce time spent fetching water and increase the quantity of a household's water, they also secure the quality of the water as compared to open sources such as ponds and streams. Interestingly, some people resist drinking water from improved sources as it tastes differently from the water that has traditionally been used. This illustrates how tastes, habits and customs must be taken into account. A measurement that merely confirms the presence or absence of facilities may or may not reflect accurately people's use of the facilities.

Natural capital

There is great variation in the degree of ease or difficulty in securing a livelihood depending on the availability of resources in the nature surrounding the communities, and also depending on climate variability and threats. Some localities are at special risk from the brute forces of nature, either through violent events like earth quakes, floods, or land slide, or through more small-scale but persistent threats such as seasonal droughts. There is variability in the presence of such risk, as there is variability in the degree to which communities are vulnerable to existing threats. Vulnerability can be reduced in several ways (see Chapter 4), and in a fine example from a village in Ghana, women get help to buy goats as a means of diversification in case the groundnut harvest fails due to droughts. The goats were considered 'saving accounts' to carry the women through difficult times. Disaster preparedness proved important in coastal India as well, for example through the construction of houses and refuge sites that were safe in case of cyclones and floods.

Human capital

Motherhood

In all three areas we visited, motherhood is an important element of a woman's social status. Being barren is a risk factor for divorce, for instance in northern Ghana. Having the right number of children is important for achieving status, and this number varies between localities. In Haiti, status to some degree increased steadily with the number of children. In Ghana, there seemed to be a pronounced wish of the women to limit the number of children due to resource scarcity; it was important to be able to care for, feed and educate the children you had. Children were seen as helpers in the house and in other productive activities, and great hope was connected to the future success of children, to hopefully securing the long-term wellbeing of the household. Giving birth was a risk to health and life, and with an increasing number of children the mother's physical health deteriorated. Ghanaian women, in an area with high child mortality, expressed great grief at the loss of children, such that both having and losing children were part of the dynamic of motherhood and well-being.

Occupation

In all the places visited, women were actively engaged in income-generation activities, but at times these activities could not be classified as one typical occupation. They could be active in several occupations simultaneously, in a diversification of livelihood that is common in rural localities. A common example is the combination of agricultural work and trading. Traditional coding of occupation in survey data, in which a person is assigned a main occupation, is not sensitive to diversified livelihood making.

Knowledge and skills

Relevant survival skills for poor ruralities can be transferred in several ways other than formal education. Examples are oral transmission across generations, and informal education through apprenticeship. For some, skills such as literacy and numeracy are acquired without formal education, and this makes informal education and life skills important areas for measurement, besides formal education. Incomplete primary education, and not only completed primary education, may secure important skills such as basic literacy. The common education classifications used in survey research may not be fine-grained enough in this regard. Also, illiterate women can be holders of vital knowledge they pass on to others, increasing their status, and through that, the quality of their living conditions. There are also suggestions in our observations that in a community where mean education level is low, having too much education can be a risk factor for women. Too much education may reduce one's chances of marriage (India). Also, a man tends to not respect a highly educated woman unless he has a higher education himself (Ghana). Being a guardian of important knowledge, or being a gatekeeper for access to resources, can strengthen the

social position of a woman regardless of other factors. In Ghana, older widows at risk for being expelled from communities (ostracized as 'witches') were given roles as 'agricultural consultants' for a local NGO working to strengthen women's social position. This made them key persons in their local communities, regulating access to resources for other community members, and their status changed from being at-risk to receiving seats next to the elders at community meetings. Treating male and female children equally when it comes to educational opportunities was considered important by women in all three areas we visited.

Health knowledge

For some types of health promoting behaviour, it is vital that husbands, and not only wives have health literacy. This is especially important when it comes to family planning, where male acceptance is vital. In poor ruralities, the mass media, especially radio, have an important role in the transmission of health knowledge. The degree to which traditional medicine or modern medicine is the first choice can be a health knowledge factor of substantial importance (Haiti).

Daily strain and timer pressure

Balance between work and rest emerged as an important factor in both Ghana and Haiti. The work load for women is heavy, and securing a livelihood is time and labour intensive. Also the main load from domestic and child care work falls on the women, all of this combined with the load from child bearing and child birth. In such a situation, there is limited time to spend in leisure activities, in organized groups, and in communication with friends, all of which could ensure additional resources for women. Factors reducing the strain on women can be of great importance, as for instance boreholes and wells that reduce time spent fetching water. Easy access to fuel for daily cooking is important, reducing time fetching fuel. The degree to which husbands support their wives and ease their loads was emphasized as a factor affecting health in both Ghana and Haiti. In India, there were reports that having a husband and children not only represented increased benefits for women, but also additional strain in life. For women, being hardworking enhances social status, and in Ghana, we were told that lazy women were not respected.

Decision latitude of women:

Having an income of her own increased the status of the woman in the household and in the community and gave her opportunities for investments on her own behalf. Such investment enabled women to improve their houses, educate their children, to pay for health care, and more. Freedom of mobility and joint decision-making with husbands were other factors of importance.

Social capital

Relationship to husband and position within household

The quality of

relationship between spouses was given great emphasis in Ghana, and also in Haiti. A good husband is faithful, non-violent, and not a drunkard. Both emotional and practical support from the husbands meant a lot for the women and could relieve some of the strain of daily living. Marriage was generally reported to increase the status of women, even if co-habitation was a very common form of partnership in Haiti. There was increased risk for widows and divorced women. For instance, male lines of inheritance in Ghana represented a route to increased poverty for women. When a husband died, his farm might very well go to his parental family, not to his widow. Sharing of resources within households was of importance, and household wealth could not automatically be considered as representing the woman's access to resources. In situations of food shortage, wives and mothers very commonly prioritised feeding their husbands and children, going hungry themselves. In polygamous households this situation was even more complicated, with the introduction of competition between the wives (and between children of different wives) for social status, lower work loads and more resources generally.

Participation in social activities and networks

Women's support networks were

strengthened through participation in organized social activities such as women's groups and churches. The degree of increased empowered for women resulting from such participation should be assessed. Participation in social networks is not often measured in larger surveys. Friends are another source of support, both at an emotional level and as providers of other resources. There are suggestions in our data that high levels of poverty in a district reduced level of support between community members, as everyone struggles to get by. Time poverty also limited the opportunities for strengthening friendships and support networks. There was village-to-village variation in level of trust between villagers, and village-to-village variation in level of organized communal activities for the benefit of the community or the needy in the community.

Cultural capital

Culture

There is local variation in the degree to which various benefits come to men rather than women. For instance, in some cultures certain nutritious food is prohibited for women and children. Old cultural patterns seem to be undergoing changes in the sites of our field visits, largely in a more individualistic direction. In Ghana, this had the consequence that younger

families tended to set up individual households rather than living in the extended family compound. This reduces the degree to which one has to share resources with others, but also reduces the level of mutual social support. The main explanation given for this change in tradition was influence from media such as movies and radio. This influence thus had paradoxical effects, spreading important health knowledge, but also changing the preferred way of living and extending the basis for social comparison. There were examples of cultural changes for the better -- concerted action between local communities changing funeral practices in ways that reduced the impoverishing effect of many very expensive and time consuming gatherings.

Religion Religion was a factor which introduced both risk and protection, very much depending on varying religious beliefs and practices. Traditional beliefs may include fear of punishment from spirits, and cause increased poverty due to the perceived obligation to sacrifice resources (sheep, goats) to ensure peace with important idols (Ghana). Religious taboos generally benefit men over women and children, for instance through taboos that do not allow women and children to eat the most nutritious food. But religion was also a strong resource and protector. At the personal level, religion carried hope and peace, helping women to accept the adversities in life due to their belief in a higher order. Religion also increased the status of women through roles in church communities. In very patriarchal contexts, the Christian faith was reported to increase the status of wives in marriage, and increase the engagement of husbands in the wellbeing of their wives and families.

Being demographically gifted Demographic factors such as the status of familial lineage and age were status. Examples of inherited positions are caste, tribe, or lines of chieftaincy. The importance of age seemed to be locally determined. In India women's status automatically increased by the age of 45. In certain cultures in Ghana, elderly women, especially widows, were at times at special risk for being ostracized.

Political capital Political capital was important at two levels: the political capital of the women, and the political capital of the local leaders. Participation in women's groups and churches increased the capacity of women for governance both at the individual level and at the group level. Women gained experience in group participation and in wording their views, needs and concerns. Participation in networks also increased knowledge of women's rights and opportunities. At a higher level, good local leadership made a difference in many villages, as a good leader concerted community action for the benefit of all. Also, networks of local leaders facilitated area level action to the benefit of many

communities. Examples from the field visits include protection of rivers from poisoning, reducing deforestation from charcoal burning, and changes in funeral practices to reduce burdens on the poor communities.

Cross-cutting observations

- Income-generating work cannot, in many cases, be captured by classifying a women into one main occupational group
- Treating male and female children equally is a valued goal for women, but far from a reality in many households
- Joint decision-making with husbands is also desired, but rare
- Non-violence of husbands, too, is desired but too rare
- Strengthened support networks through participation in organized social activities such as women's groups or churches positively affects women's living conditions

All points except the first entail a strong element of gender equity and empowerment, suggesting the importance of social justice as the foundation for the health and wellbeing of women in poor ruralities.

Table 1. Respondents' understanding of what living conditions affect women's health and well-being; select rural districts in Ghana, Haiti and India.

		GHANA	HAITI	INDIA
FINANCIAL OR MATERIAL CAPITAL	Having an income of her own.	X	X	
	Ownership of items with local importance.	X		X
	Quality and quantity of food – food security.	X	X	
	Increase of financial security through participation in various types of women's cooperatives.	X		
PHYSICAL CAPITAL	Really accessible quality primary health care, considering distance, transport options, fees, and cultural appropriateness of care.	X		X
	Distance to market town.	X		
	Availability of sanitary facilities.	X		
	Water – quality and quantity available	X		
NATURAL CAPITAL	Ease or difficulty of securing a livelihood in the natural environment	X		
	Disaster proneness or risk		X	X
	Disaster vulnerability	X		
	Disaster preparedness (disaster including for instance drought, not only violent incidences)	X		X
HUMAN CAPITAL	<u>The role of motherhood</u>			
	Having enough children to achieve status in community	X	X	
	Not having more children than you can support well	X		
	Being able to educate one's children	X	X	

	Children as helpers in domestic and other types of work	X	X	
	Children as future economic support	X		
	Giving birth as a health risk	X		
	Grief over loss of children	X		
	<u>Knowledge</u>			
	Skills acquisition through oral transmission between generations		X	
	Skills acquisition through informal education such as apprenticeship		X	X
	Status through being able to teach others important skills even if you are formally uneducated.		X	X
	Status through community positions despite lack of formal education.	X	X	
	Literacy as a factor increasing status independent of formal education.		X	X
	The interaction of women's and men's education: A woman with a high education is not necessarily respected by men who do not have a high(er) education.	X		
	Having too much education as a factor potentially reducing women's chances of marriage.			X
	Differentiation between incomplete primary education and complete primary school education in measurement.	X		X
	Treating male and female children equally.	X	X	X

	<p><u>Health knowledge</u></p> <p>Preference to traditional or modern medicine as first health care choice.</p> <p>Level of health (behaviour) knowledge not only of women, but also of husbands. Of special importance is family planning acceptance among men.</p> <p>Media, especially radio, as an important channel for health education.</p> <p><u>Daily strain and time pressure</u></p> <p>Balance between work and rest.</p> <p>Availability of time for leisure and social activities in the daily schedule of women.</p> <p>The amount of time and effort it takes to secure enough water, food and fuel.</p> <p>The degree to which husbands assist in household and child care tasks.</p> <p>Respect through efforts to contribute to household and community success.</p> <p>Marriage and family as potential introduction of additional strain into women's lives.</p> <p><u>Decision latitude of women</u></p> <p>Increased economic independence</p>			
			X	
		X	X	
		X		
		X	X	
		X	X	
		X	X	
		X		X
				X
		X	X	

	Joint decision-making with husbands	X	X	X
	Freedom of mobility			X
	<u>Being demographically gifted</u>			
	Increase of status above certain age thresholds.			X
	Inherited position, such as caste, tribe or similar.	X		X
	Risk of being ostracized for especially elderly widows.	X		
SOCIAL CAPITAL	<u>Relationship to husband and position within household</u>			
	Faithfulness of husband	X	X	
	Non-violence of husband	X	X	X
	Non-drunkard husband	X		
	Friendship and communication between spouses	X		X
	Respect from husband	X	X	
	Father's taking an active role with the children	X	X	
	Sharing of workload	X	X	
	Marriage as increasing status relative to cohabitation.	X	X	
	Increased risk for widows and divorced women.	X		
	Living in polygynous relationships as introduction of new elements of competition over status, work load and resources.	X		
	Sharing of resources (including food) within households.	X	X	

	<p>Mothers can go hungry to let their children and husbands eat.</p> <p>Increased respect through contributing financially to the livelihood of the household.</p> <p>Increased self-confidence through participation in women's groups.</p> <p><u>Participation in social activities and networks</u></p> <p>Strengthened support network through participation in organized social activities such as women's groups and churches.</p> <p>Degree of empowerment through participation in organized networks.</p> <p>Informal support from friends.</p> <p>Time poverty due to hard work limiting time to spend in networks and with friends.</p> <p>Village-to-village variation in level of trust between villagers.</p> <p>Village-to-village variation in level of community support.</p>	<p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>	<p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>	<p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>
CULTURAL CAPITAL	<p><u>Culture</u></p> <p>Degree to which various benefits come to men rather than women.</p> <p>Changing family and housing patterns in an individualistic direction as a factor reducing support from extended family.</p> <p>Exposure to media as speeding cultural changes.</p>	<p>X</p> <p>X</p> <p>X</p>		

	<p>Change of old traditions for the better of women through concerted local action.</p> <p><u>Religion</u></p> <p>Religion as introducing taboos and fears.</p> <p>Religion as a factor deepening poverty.</p> <p>Religion as primarily benefitting men over women.</p> <p>Religious activities introducing positions of status for women.</p> <p>Religion as a source of hope and peace.</p> <p>Religion increasing the status of women in marital relationships.</p> <p>Religion as increasing the engagement of husbands in the wellbeing of their wives.</p>	<p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>	<p>X</p>	
POLITICAL CAPITAL	<p>Good local leadership at various levels influencing living conditions.</p> <p>Presence of networks as facilitator of cooperation between villages for the common benefit.</p> <p>Strengthening of women's capacity for governance through participation in women's groups and churches, at both individual and group level.</p> <p>Increased knowledge of rights and opportunities through participation in women's groups and churches.</p>	<p>X</p> <p>X</p> <p>X</p> <p>X</p>	<p>X</p> <p>X</p>	<p>X</p>

Chapter 3. The Ghana Reference Group Meeting, August 2008

Torill Bull

Background

Being poor is associated with increased risk for poor health. This has been confirmed through international research over the last decade, and it applies in all regions of the world (1). Not only do the poorest suffer worse health than the richest, but every step up a social ladder has been shown to be associated with better health. Usually research on social inequalities in health makes comparisons at a national level (e.g., poorest quintile of a nation versus the richest quintile), or at an international level (different nations' wealth and health averages are compared).

It is common to think of people living in severely impoverished areas as being uniform in their suffering, both in terms of poor health and low quality of life. However, even within the poorest rural areas, in Africa for instance, there is variability in both wealth (though all must be considered poor) and health. Some people are flourishing, reporting excellent health and high satisfaction with life, while others are doing poorly. In our earlier research in Northern Ghana, we observed that this health variability is not explained by variation in the 'classic' social indicators, income and expenditure (2-4). This leads to the research question of our project: What are the social determinants of health in very poor ruralities?

The first activity of the project was to assemble a Ghana Expert Reference Group, and hold a consultation in Bergen in April 2008, to begin exploring the issues mentioned above.

The information we obtained from the Reference Group, which is reported below, is more comprehensible when informed by some understanding of the living conditions in Savelugu-Nanton, as summarised in the box on the following pages.

Health of children under 3

- Stunted: 37%
- Underweight: 41%
- Diarrhoea last two weeks: app. 50 %

Caregiver health knowledge

- Uneven
- 60 % of mothers do not know that a child needs more fluid if it has diarrhoea

Sanitation

- 2 % of households use latrines or toilets
- Children use rubbish pits
- Adults go 'free range'

Water

- 20-30 % of households, depending on season, have safe source of drinking water (borehole or protected well)
- More common: dugouts, dams, ponds, rivers, streams, unprotected wells
- 50 % treat drinking water, typically with basic filter

Health facilities

- 66 % of communities have Traditional Birth Attendant
- Less than 10 % of communities have maternity home or community clinic
- None have health post or health centre
- When travelling to official clinics, respondents report that medical supplies are usually not available

Agriculture

- Mostly production, but also some processing, of agricultural products
- Staple crops in order of importance (1) maize, guinea corn, yam, (2) ground nuts, ocra, (3) rice, millet, leafy green vegetables
- Hired tractors or hand hoeing
- Monocropping and intercropping
- 58 % use commercial fertilizer
- 13 % use improved seeds
- 86 % use exchange labour
- 71 % use at least some hired labour

Diets

- Closely related to agricultural production
- One-third of household total expenditure is used on staple grains/roots, 7 % on vegetables, 5 % on legumes
- The amount of fish and dark green leafy vegetables consumed is so small that it has no dietary importance
- Only 25 % eat meat of any kind
- Very few eat eggs or mangos, which are excellent local sources of Vit.A

Asset ownership

- Modest, with sharp gender differences
- 75 % of men own bicycles
- Less than 1 % of women own bicycles
- Men most commonly own bicycles, sofas, radios, cassette players, watches or clocks, hunting gear
- Women most commonly own bowls and trunks

Credit

- Normally from friends, relatives, acquaintances
- Most common: short term loans for agricultural input with payment in kind of harvest
- Also loans for business purposes
- 50 % of households have some kind of credit, 25 % of women, and only 12 % of mothers of children below 3.
- High implicit interest rates (72 % per annum)
- Average value of agricultural/business loan: 250,000 cedis (inflated by some large loans reported)

Household composition

- Average size 14 members
- 50 % dependents (young and elderly)
- Extended families: 60 % of households have at least three generations, 60 % of households have at least 2 distinct marital units
- Mix of polygamous and monogamous marriages
- Individuals are mobile due to childbirth visits, seasonal work, social visits
- Gender imbalance in certain age groups: males outnumber females in the 13 – 18 year group, while females outnumber males in the 19 – 35 year group

Schools

- 60 % of communities have primary school or School for Life Programme
- 10 % have junior high school
- None have senior high school

Literacy levels

- On average, 11 % of under 18s can read a simple sentence in any language
- Less than 2 % of women under 18 can read a simple sentence in any language
- 13 – 18 year olds: 14 % of girls and 38 % of boys can read a simple sentence
- In app. 50 % of households no one can read

School attendance

- Has improved
- Of 6 – 18 years old, less than 50 % have attended school (58 % boys, 37 % girls)

Transportation

- 50 % of communities are along a tarred or graded road
- 1/6 is served by commercial transportation
- On average, one has to travel more than 5 kilometres to reach commercial transportation
- Transportation options for agricultural purposes are very limited

Ghana Reference Group Consultation Methodology

For the Savelugu-Nanton Reference Group, we selected ten professionals using a snowball sampling method. Their areas of expertise covered anthropology, sociology, law, psychology, social geography, development studies, public health, health promotion, gender studies, and criminology. The group includes four professors, two post-doctor scholars and four junior researchers with recently earned PhDs or in the process of completing their PhDs. Various members of the group are affiliated with the University of Ghana (Accra), the University for Development Studies (Tamale, Northern Region of Ghana), the Navrongo Health Research Centre (Navrongo – Upper East Region, Ghana), Cambridge University (UK), and the University of Bergen (Norway). Six of them are Ghanaians by birth, two had lived in Ghana for long periods of their lives, and the remaining two had extensive research experience in Ghana or other African ruralities, on issues of great relevance to our research question. Four participants were male, six were female.

Nine of these ten professionals were gathered in Bergen, Norway, in August 2008. This gave us the opportunity to arrange a Dinner Meeting with a dialogue on selected questions. The 10th member of the group was consulted in meetings in Bergen in June 2008.

The nine participants at the Dinner Meeting were given information about the intention behind the dinner at the time of invitation, in the form of a short written introduction to the research question. Following the dinner, the members were given a sheet of paper containing the following text:

1. *Whom shall we discuss:*

Women with children three and under, living in the Savelugu-Nanton region of Northern Ghana

2. *What is the issue:*

Their self-reported health compared with women their age is highly variable (with graph from analyses illustrating this fact)

3. *What is the question of the evening:*

What aspects of their social, psychological, economic, cultural (et cetera) situations might explain (in part at least) the variability in health?

Put in a slightly different way, what do you think the important social determinants of health are, for these women, and for people in general, living in this region?

The group was also informed that classic economic measures failed to explain the health variability in this sample of the Savelugu-Nanton study.

In addition to the nine Reference Group members, two members from the research team were present. While one functioned as a chair of the dialogue, the other had the responsibility of taking notes of the full dialogue. The notes were extensive, trying to capture the exact words and expressions chosen by the participants. However, given that no sound recording was made, the citations used in this report are not always rendered in the precise wording of the participants, despite the efforts made to be precise.

The dialogue was organized as a round table in the following manner:

1. A short introduction was given by the dialogue chair.
2. A round was made around the table with each participant in turn offering their comments to the questions above.
3. A short commentary was made by the chair, redirecting attention to questions of particular interest.
4. A new round was made around the table with each participant adding to the previous comments.
5. The chair rounded off the dialogue with some concluding remarks.

Shortly after the dialogue, the notes were written out in detail. These notes provided the data for the following analysis, with the addition of the notes from the discussions with the 10th member in June 2008.

The Reference Group contribution was intended to extend our insight in the overall work with the larger project. It was never intended to be an independent scientific work, and the information obtained from the dialogue has not been considered in light of existing literature and theory. Nevertheless, a fairly thorough methodological approach was chosen with systematic text condensation over several steps. Meaning-bearing units were identified and de-contextualized, and next coded in categories and sub-categories. As a final step a search was made for overarching themes emerging from the sorted material.

Results

Figure 1 shows an overview of important key constructs that emerged from the dialogue. In addition to focusing on determinants of health for women and children in the area, the Reference Group paid much attention to methodological issues. As an important example, it was not automatically accepted as a fact by the Reference Group members that a woman's health was actually at the level she reported it to be in the Savelugu-Nanton survey data. A point of special interest was reasons for a woman to report her health as better as or worse than that of other women. In the following, the content of the dialogue is reported following the categories from Figure 1.

Geographical location

The background Box highlights the overall geographical situation of the villages, in this case Savelugu-Nanton in Northern Region of Ghana, shaping conditions for health through availability of natural resources, distance to various kinds of services (education, health care, jobs etc), and also shaping the setting providing the norms for what is considered health, wealth and poverty. This geographical background also shapes the content of the middle box in Figure 1 with its two main elements of *resource availability* and *tradition and culture*, which again influence the more detailed level in the three internal boxes.

Resource availability

Food insecurity was the element of poverty that received most attention in the dialogue. Seasonality played a major part in this, with relative affluence during some months compared to others. Social networks, maybe especially more well-off contacts, might substantially increase the flow of resources to a person or family.

Tradition and culture

Several elements from tradition and culture were held forwards as being health-relevant. There is a tradition for a strong patriarchy, with mostly male dominance over resources. Motherhood is a very important part of a woman's identity, shaping position and self-esteem.

"Children give personhood more than marriage does".

"A person is a person with other people".

For many women in the Savelugu-Nanton area, the experience of motherhood is strongly affected by the tradition of 'childbirth visit', with mothers giving birth returning to their parental home and staying there for up till three years, receiving care, nutrition and ideally being protected from a too heavy work load.

Polygamy is another cultural factor of health importance. It is common for a man to have several wives, creating a hierarchy of wives which represents a social stratification within households. Also spirituality and faith in ancestors may have an influence, influencing cognitive processes regarding health, possibly in a fatalist manner.

Thus, the geographical location shapes resource availability and tradition/culture. At the next level, resource availability and tradition/culture influences *resource allocation* and *cognitive processes*. A third box of methodological issues is also inserted at this level of Figure 1, to allow for a fullest possible rendering of the content of the dialogue. The categories in this box are not thought to influence health, though, but rather suggest reasons for being cautious in interpreting the survey results from the Savelugu-Nanton Household Survey.

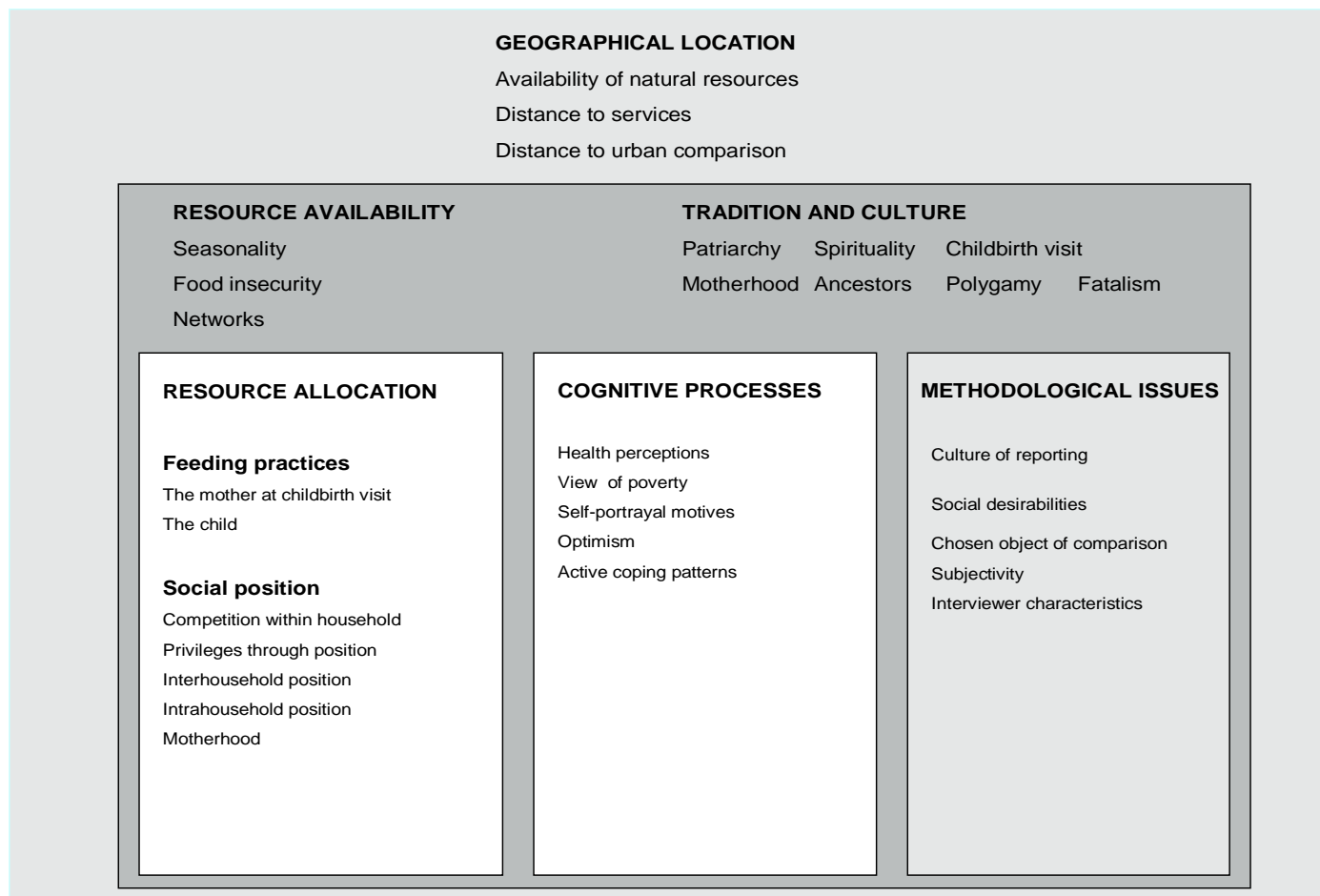


Figure 1. An overview of categories and keywords resulting from the analysis of the notes from the Reference Group proceedings.

Resource allocation

In a context of resource scarcity, the allocation of available resources within a household becomes a main issue. Two major categories emerged here – feeding practices and social position, both interrelated. Food allocation follows social position within the household. Thus not only the household's income or expenditure, but also a person's position *within* the household, influence the type and amount of food and other resources this person receives. Feeding practices follow certain traditions, with the mother at childbirth visit and her child being high in the hierarchy when it comes to food allocation. It is not uncommon for a mother-in-law to prepare especially nutritious food for her daughter-in-law. So, a mother at childbirth visit and her child may have a larger share of the resources within a household than they might have at other times in the life cycle.

"A child below three is a god, a goddess".

"Mothers look healthier than other women".

There is also an intricate system of social position within a household, with the household head at the top. Position will bring privileges, both for share of the work load and for resource allocation, with obvious health consequences.

The household head may be living with his (in some cases her) family and the families of several sons (and in some cases daughters) in the same household. Both the household head and his sons may have several wives. A woman's position in the household is therefore influenced by the status of her husband within the household (by sequence in son hierarchy), by her seniority in the wife-hierarchy in polygamous marriages, and by her status related to motherhood.

The Reference Group was not decisive on what decided wives' status within a polygamous family. A young wife might be high in status because of beauty, strength and fertility. An old wife might be high in the hierarchy if she was the first wife. This is an area of interest for further investigation. In addition to intra-household position, it was acknowledged that inter-household position in the village is also of importance for a woman's health. This point was not much explicated on in the discussion.

A woman's position through motherhood was given much attention by the Reference Group. Fertility gives a woman status.

"Children are a blessing from the ancestors".

"Your importance depends on how many children you have".

"In the Western world, children mainly have psychological value; with the consequence that one child is enough. In many areas, children have economic value, with the consequence that 'the more the better'. In Ghana, children have social value, also with the consequence that 'the more the better'".

Your social position as a wife or woman depends on having children. Having given birth to many children increases your status. The age of your children will also be of importance: as child mortality is high, a young child cannot be considered as certain to grow up. Therefore, having older children

might be a more secure way to status (though this seems contradictory to the reported high status of the very young child and mother in the period of the childbirth visit).

It is shameful for a wife not to bear children. This might influence a woman's perception of whether her health is good or poor. A childless wife will have a lower position in the household and therefore be at risk of receiving less of the available food and to having an increased burden of work.

Cognitive processes

The Reference Group was given an example from the Savelugu-Nanton Household Survey of a question where the women were asked whether their health was good or bad compared to other women their own age. The discussion on cognitive processes evolved around two aspects of this: (1) cognitions of relevance to whether one perceives one's own health as good, and (2) cognitions related to self-portrayal.

Concerning (1), an optimistic culture was given as a reason for a positivity bias – women might tend to report their health as better rather than worse.

"People are generally happy in Ghana".

Also, the culture is one of active coping. People tend to try to make the best of things and to take steps to protect or improve their health. Such activities might spin perceptions of one's own health in a positive direction.

"It is a Ghanaian philosophical outlook that you DO something. You seek alternative health care, build up your body during pregnancy etc. And, when you are active regarding your health, it can make you believe you are healthy".

Another important issue related to social comparison processes. Even if health in the Savelugu-Nanton district might be poor in general judged by health levels in other areas, comparison is done locally and may lead a woman to make a more positive health report than might have been the case had she compared herself to women in less poor regions. The distance of a surveyed sample to areas of comparison might therefore be of importance regarding the validity and reliability of survey data: if the people surveyed live close to a more urban or developed area, this might influence their health perception in a negative direction

Fatalism and spirituality might also influence health perception in a positive direction, as it is prudent to accept what the ancestors or gods have intended for you. But the influence might also be in a negative direction:

“What does it help if you are objectively healthy if you believe you have been bewitched?”

The local view of poverty is also interesting. The population of Savelugu-Nanton might not consider themselves as poor.

“If you have a household, cattle, two wives – you are not poor. If you can provide a healthy, hot lunch – you are not poor”.

“The more you are aware of your poor status, the poorer you become”.

Concerning (2), a woman in Savelugu-Nanton might have many reasons for portraying herself as having better health than she actually feels she has: as there is a fight for status within a wife hierarchy, self-portrayal becomes vital to retain or gain status. A healthy wife is of high value. Also, if a woman reports not having enough resources, she is actually saying that her husband is not providing for her as well as he ought. If she is worse off than other women, she might be giving her husband away as being a worse provider than other men.

“No-one wants to say ‘I don’t do well’. Most will say ‘I do well’, this equals ‘My husband takes care of me’. Or else, another husband takes better care of his wives”.

Methodological issues

The Reference Group paid much attention to the fact that the survey data, at least the item used as an example, are self-reported and therefore subjective in character.

“We don’t know anything here. It is all logical guessing”.

They wished for objective health measures. In subjective health reporting they saw the threats to validity of self-portrayal motives, as discussed above.

"It's about how people answer questions – what they want to communicate".

A positivity bias might make the data less accurate.

Also the choice of object of comparison was considered important in rating one's health compared to others: who do you compare yourself to? Is the choice made at the ease of the moment, do you compare yourself to one person of special interest, or do you make a thorough well-founded comparison based on wider considerations?

The characteristics of the interviewer were also thought to be important. Some members of the Reference Group were of the opinion that a local interviewer would get the most honest answers, as you would not talk negatively of your own to strangers:

"You don't point with your left finger" (Meaning, you don't say anything bad about your own people)

Other members of the group thought the distance to a non-local interviewer would make self-disclosure easier. Being perceived as 'local' could be decided by both ethnicity and by area of origin.

A final methodological issue was the culture of reporting. In some African cultures it is said to be polite to answer in the negative when asked how you are doing. In other African cultures it is proper to give a good report of health.

Reference Group recommendations to the project

The Reference Group specifically recommended that the project expanded the data with qualitative information from the local area exploring health perceptions, poverty perceptions, and issues of within-household position from the view of mothers.

Objective measurement of health was considered necessary to improve quality of quantitative data. The recommendation was also made to focus on what led a woman to report her health as being 'worse' rather than 'better' than that of other women her age.

A woman's position within a household should be explored, and factors of importance here might be her seniority as a wife in a polygamous marriage, and the number, age and well-being of her children.

Overarching themes

The following overarching themes could subsume the content of the Reference Group dialogue referred above: resource shortage, struggle for survival, worries, competition, position, protection, status and shame, identity through motherhood.

A general resource shortage leads to a struggle for survival both between and within households. There is worry related to upholding the resource flow to oneself and one's children. Within a household, members compete over scarce resources, and social position within a household is a determining factor for resource allocation. A woman's position is determined by her relationship to the household head, to her husband, and to other women in the household. A higher position leads to protection and a greater flow of resources.

External networks might also protect a woman through increased inflow of resources. A woman's position is also to a very strong degree related to motherhood. Motherhood gives status, barrenness creates shame. Being a mother – preferably of many healthy children – is a strong element of a woman's identity. This identity feeds back to her health perception and to her social position within the household, determining her share of resources and work load.

Conclusions

This report has presented the content of the Dinner Dialogue with the expert Reference Group for Ghana gathered in Bergen, Norway, in August 2008. A full scientific analysis of the material has not been undertaken. The aim has been to extract learning that may inform our further search in literature and data analyses for the project Social Determinants of Health in Very Poor Ruralities.

Three major recommendations seem to emerge from the work with this Reference Group:

- Qualitative data are necessary as a supplement to the quantitative data in our hands.

- Subjective self-report of health should be complemented with objective measurement of health.
- The position of a woman within her household should be explored as a social determinant of health for women in very poor ruralities, at least in the Savelugu-Nanton region of Ghana. This position is related to motherhood and to a woman's relationship to other grownups in the household.

References

1. CSDH. Closing the gap in a generation: health equity through actions on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008.
2. Mensah J. Child Diet Diversity among children under 38 months of age in Savelugu-Nanton District of Northern Ghana [Masters thesis]. Bergen: University of Bergen; 2008.
3. Boateng R. Are symptoms of diarrhoea severity associated with socio economic status: a case study of Savelugu-Nanton district in Ghana? [Masters Thesis]. Bergen: University of Bergen; 2008.
4. Baafi AA. Is immunisation rate in the Savelugu/Nanton district associated with socioeconomic status? [Masters Thesis]. Bergen: University of Bergen; 2008.
5. International Food Policy Research Institute, Unicef, Tamale University for Development Studies. Report of the 2001 Survey in Savelugu-Nanton District. 2003.

Appendix I

Members of Ghana Expert Reference Group.

David and Brenda Mensah were added to the Reference Group for future referrals after the field visit in April 2009. Christine Oppong was interviewed in Bergen in June 2008 and the information from the interview was integrated with the report from the Reference Group meeting which was held in Bergen in August 2008.

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Chapter 4. The India Field Visit, April, 2009

Maurice B. Mittelmark

Overview of Activities

The field visit commenced in the offices of the Voluntary Health Association of India (VHA) in New Delhi, with an extended briefing on 13 April 2009, provided by Executive Director Alok Mukhopadhyay, focussed on the Voluntary Health Association of India's (VHA) work in disaster-prone regions of India.

Also at VHA headquarters, a seminar was conducted on 13 April 2009, focussed on the decade of VHA work in Orissa, India. The presenter was Mr. Shisir Ranjan Dash, Programme Co-ordinator, VHA Aparajita, Bhubaneswar, Orissa. The main discussant was Professor Ashish Bose, Institute of Economic Growth, New Delhi, and Member, National Commission on Population. The briefing and the seminar provided me with a good introduction to the work of VHA, my host institution.

On 15 April 2009, Mrs. Itishree Kanungo, Project Manager, VHA Aparajita, guided me in visits to three coastal villages, two of which participate in VHA self-help projects.

The Reference Group meeting was held on 16-17 April 2009.



Summary of observations

The field visit illuminated a number of lessons regarding social determinants of health in villages of Orissa, India. These should be taken forward by the project, with regard to both the qualitative and quantitative studies underway in India, but also in the ongoing work in Ghana, Haiti, Peru, Canada and Tanzania. Ten key findings have particular relevance:

- Women's social position in the community is influenced by inherited position, caste, tribe, economic situation, education-related factors, and social network factors. This suggests that inherited position should be measured, which is not included in the Demographic and Health Surveys (DHS). Factors which may be important to consider as indicators of a women's social position include having sought-after skills and imparting them to others; having sons and especially married sons; being demographically 'gifted', i.e., being 45 or so year of age and older.

- A women's social position within the household may affect her physical and mental well-being. Indicators of having a high social position in the home include having a husband who has a sharing relationship with his wife (decision-making, eating together, contraceptive choices, etc), having freedom of mobility, having freedom from domestic violence, and treating male and female children equally.

- Economic situation is signalled by a household's ownership of key material goods including a motorbike, a television, and especially a mobile phone, and having a concrete rather than a mud or thatched abode. This may call for alternative, more precise approaches to measuring material wealth than the use of the PCA Wealth Index, as in the DHS.

- Education-related factors help determine a women's social position in the community, but informal as well as formal education is important. The ability to read and to teach others to read places a woman in a higher social position regardless of her level of formal education. Too much education may place a woman at risk of being unmarriageable. The practice of treating education level as a constantly increasing good, as it is coded in the DHS, should be reconsidered. Literacy may be a more valid indicator of social position than formal education level. Informal forms of education should be measured. Measures of formal education should differentiate incomplete from complete primary education.

- Women who participate in social networks, such as self-help groups, enjoy many advantages that can have direct and indirect influence both on social position and health. A distinct disadvantage of the DHS is its lack of measurement of social network involvement. The nature of participation in social groups is important. The degree to which participation is empowering should be measured.

- A women's social position in the community may not be highly correlated with the position of the household she lives in. Even a women living in a very poor home may enjoy high social status based on her ability to contribute to the community, and the respect and good reputation that brings.
- For everyone in a village, the degree of access to really accessible primary health care is a determinant of health. This is widely appreciated in the academic community, but additional dimensions that seem less appreciated are that primary care must be sensitive to the living conditions and social and special health needs of the rural poor. It is not just access to care that is important, but also quality and appropriateness of care.
- While being married is a protective factor in many societies, marriage may be a risk factor for poor health for many women in Indian villages, as it brings with it a host of burdens and stressors that unmarried women do not experience.
- Very poor ruralities are almost inevitably arenas also prone to disaster, and disaster preparedness in the context of well-functioning social networks protects health. Measures of disaster preparedness are needed to understand how this SDH and health co-vary.
- Political capital is a very important SDH, it is successfully measured in surveys like the European Social Survey, and it should be measured in health studies in very poor places.

Introduction to Orissa¹

Odisha/Orissa is a state of India, located on the east coast of India, by the Bay of Bengal. It is the modern name of the ancient nation of Kalinga, which was invaded by the Maurya Emperor Ashoka in 261 BC. The modern state of Odisha was established on 1 April 1936 as a province in British India, and consists, predominantly of Oriya speakers. 1 April is therefore celebrated as *Utkal Divas* (Odisha Day).

Odisha is the ninth largest state by area in India, and the eleventh largest by population. Oriya is the official and most widely spoken language. Odisha has a relatively unindented coastline (about 480 km long) and lacks good ports, except for the deepwater facility at Paradip. The narrow, level coastal strip, including the Mahanadi River delta supports the bulk of the population. The interior of the state is mountainous and sparsely populated. Deomali at 1672 m is the highest point of the state.

¹ This section is a direct citation extracted from <http://en.wikipedia.org/wiki/Orissa> on 11 February 2010.

Odisha is subject to intense cyclones. The most intense one, in October 1999, Tropical Cyclone 05B caused severe damage and some 10,000 deaths.

Bhubaneswar is the capital of Odisha. It is famed for its magnificent temples, numbering around a thousand. Katak, the former capital of Odisha, is 22 km from Bhubaneswar. According to the 2001 census of India, the total population of Odisha is 36,706,920, of which 18,612,340 (50.89%) are male and 18,094,580 (49.11%) are female, or 972 females per 1000 males. This represents a 16.25% increase over the population in 1991. The population density is 236 per km² and 85.01% of the people live in rural areas and 14.99% live in urban areas.

Odia is the official language of Odisha and spoken as a native language by about 90% of the people. Other linguistic minorities in the state are Bengali, Hindi, Telugu. The literacy rate is 63.61% with 75.95% of males and 50.97% of females being literate. The proportion of people living below the poverty line in 1999–2000 was 47.15% which is nearly double the all India average of 26.10%. Scheduled Castes and Tribes form 16.53% and 22.13% of the population state, constituting 38.66% of the State population. Some of the important tribes are Santhal, Bonda, Munda, Oraon, Kora and Mahali.

Data of 1996–2001 showed the life expectancy in the state was 61.64 years, higher than the national value of years. The state has a birth rate of 23.2%, a death rate of 9.1%, an infant mortality rate of 65 per 1000 live birth and a maternal mortality rate of 358 per 1,000,000 live births. Odisha has a HDI of 0.579 in 2004.

The dominant ethnic group are the Odia people. Many other groups are defined as Scheduled Tribes. Odias comprise 75% of Odisha's population while various tribal groups comprise most of the rest.^[15]

The official language of the state, spoken by the majority of the people is Odia. Odia belongs to the Indo-Aryan branch of the Indo-European language family, and is closely related to Bengali and Assamese. A few tribal languages belonging to the Dravidian and Munda language families are still spoken by the Adivasis (original inhabitants) of the state. The state has a very opulent cultural heritage, one of the richest in India. The capital city of Bhubaneswar is known for the exquisite temples that dot its landscape. The famous classical dance form, Odissi originated in Odisha. Contemporary Odisha has a proud cultural heritage that arose due to the intermingling of three great religious traditions – Hinduism, Buddhism and Jainism. The culture of the Adivasis (the original inhabitants of India) is an integral part of modern Odia heritage. The majority of people in the state of Odisha are Hindu.

Methods

Interviews with three key informants were conducted in New Delhi and in Bhubaneswar, lasting between 1 and 4 hours. All informants hold posts with VHAI, at three levels of the organisation. One informant, who provided the longest interview, is a rural development expert from Orissa with fifteen years field experience including ten years in two of the three villages where focussed discussions were held with village self-help group members.

The key informant interviews were not guided by an interview guide, nor were they recorded. Field notes were taken and used to document the content of the interviews within one day of each interview. Each informant had read beforehand a detailed overview of the project and its goals.

The main topics covered were:

- (1) the 10-year history of disaster planning, relief and recovery/rehabilitation, and community capacity-building in a coastal region of Orissa that was devastated by the 1999 super cyclone in which more than 10,000 people died, virtually all livestock perished, and the vast majority of structures were levelled;
- (2) the strategy of helping villagers to establish self-help groups, to consolidate their strengths and develop their skills in order to build capacity both to cope with natural disaster and to strengthen the foundation for improved quality of life in the villages;
- (3) the SDH in the villages, both in general and with specific regard to women.

The degree of emphasis on these three topics varied from interview to interview.

The focussed discussions with self-help groups in three villages lasted between 1-2 hours each. The discussions were not recorded, nor were field notes taken at the time. Within 24 hours of the discussions, they were documented at the level of detail provided in this report. The discussions were explicitly two-way discussions, with me posing questions to the self-help group members, and they in turn posing questions to me.

In the villages I communicated in English, the self-help group members spoke in Hindi, and VHAI's Itishree Kanungo acted as translator. The discussion in Village I was with a self-help group of male potters, the discussion in Village II was with a self-help group of women engaged in a variety of small

income generating activities, and the discussion in Village III was with a women's self-help group engaged in savings and making small loans to generate profit. The groups in Villages I and II had been in operation for 10 years and were established with the assistance of VHAI in the aftermath of the super cyclone of 1999. The group in Village III had been established for 18 months, and VHAI had no connection to the group. The discussions in Villages I and II included the self-help group members only. In Village III, a large group of men, all farmers, joined the discussion and dominated it to the point that only one woman spoke.

The Reference Group meeting was convened in a hotel meeting room in Bhubaneswar, the capital of Orissa. The Reference Group meeting commenced with a one hour overview of the project, its goals and the aims for the Reference Group (the PowerPoint slides I used are included in Appendix II). I took notes of the ensuing discussions, answered questions put to me, and reacted to the discussions as requested by the Reference Group members. VHAI staff member Ms. Anjali Gupta took notes of the meeting and these are presented in Appendix I to this report. The meeting was held in English at the preference of the Reference Group members.

Results

Key Informant Interviews

Two of the key informant (KI) interviews had the aim of illuminating the context of VHAI's work in India as a whole and in Orissa in particular. The broad portfolio of work of VHAI was described, and the history and course of its disaster aid work in the region was charted. The information from these interviews complemented information gained beforehand from documents provided by VHAI. As the aim of these interviews was to help me better comprehend the experiences in the village discussions, no summary of results from these interviews are provided here.

The third KI interview was with a VHAI staff member, a professional woman with many years experience working with villagers in development initiatives. The interview focussed on the social determinants of health (SDH) of women living in the villages that were to be visited.

The KI confirmed that a women's social position is a key SDH, and when asked what determined social position, the KI mentioned three factors, in approximate order of importance: economic situation, education and networking. Probing further about these three determinants of social position, the interview turned first to economic position. The KI explained that in any village, all villagers were aware of the relative economic position of all households, and household economic

position depended to a large extent on two factors, the possession of key goods and the quality of housing.

Amongst the key goods are possession of a motorbike, a television, and a mobile telephone. The mobile telephone has important instrumental value, as it aides in connectivity and networking. The KI cited as an example the importance of a mobile telephone in facilitating business dealings – those with goods to sell and having a phone are easiest to contact, and can therefore expect to benefit financially from the phone. Another sign of economic well-being is the possession of a house constructed of concrete, rather than the common mud and thatched hut. In the coastal areas of Orissa, the importance of having a concrete house lies in its resistance to flood waters, expected once or twice every year. Since the super cyclone of 1999, villagers with adequate means have replaced mud homes with concrete ones, but many households remain sheltered by vulnerable mud/thatch structures.

Turning next to education, the KI described the seemingly paradoxical situation that it was possible for a women to have too much, or too little education, depending on her circumstances, but that literacy and the ability to teach others placed a women at a social advantage regardless of her formal education level. Regarding the ‘problem’ of too much education, the KI explained that the parents of a women of marriageable age might well have difficulty finding a suitable match were she educated at a level above that of the eligible men. So, schooling up to and including the official level of 10 years is optimal for marriageability, and also provides literacy, which imparts other practical advantages. The KI cited the example of a woman able to write an official letter, to a bank for example, concerning a loan. This ability provides an advantage over having only oral communication with bank officials, since India has a Right to Information law, in which the author of a letter has the right to know its disposition by the receiver. This creates a chain of accountability that is advantageous to literate women – and all literate citizens – in their communications with bank and government officials.

The third factor affecting social position is networking, with women having extensive and active networks at an advantage both with regard to possibilities for formal and informal social exchange, and the exchange of practical help/good/activities. Networks provide opportunities for synergy, as in self-help groups which individuals pool resources and thereby attain advantages that no women could attain alone.

Summarising findings from this KI interview, a women's social position in a village is influenced both by material wealth – things owned by a household and the quality of the house itself – and by relationships a women creates with people outside the home. The KI also acknowledged the influence on social position of caste and tribe (and from the reference group discussions, the importance of inherited social position -- apart from caste and tribe – was emphasised).

This KI also explained that there is not necessarily a close correspondence between the social position of a household and of a women resident there. She cited the example of a women living in a poor household, having nevertheless a good social position in the community by dint of her capacity to make contributions to community welfare (as, for example, by participating actively and effectively in a self-help group).

Discussions with Village Self-help Groups

Turning to the results of the village discussions, we begin with the visit to Village I, where there is a long tradition of pottery-making, an activity secondary in importance in this village only to agriculture and animal husbandry. For many years, the village potters made large, crude pots intended for local, practical use, as water receptacles, for example. Following the super cyclone of 1999, VHAI worked with the villagers to determine ways to turn existing skills to community capacity-building advantage. The possibility of increasing the quality and variety of pottery, and selling pottery at external markets was recognised, and VHAI aided the potters in forming a self-help group dedicated to that purpose. A key aspect of VHAI's work was connecting the potters to external markets.

The potters explained how the advancements in their professional skills not only provided new income generation, but also a rise in social status in the village. Prior to 1999, pot making was low prestige work, and young men did not aspire to follow in the pot-making father's footsteps. There was clear evidence that this situation had changed, and about half the discussants were men in their early 20's, which had chosen to enter the craft because it is an attractive livelihood choice.

It was evident from a demonstration of pottery making that the potters take pride in their ability to use modern pot-making machinery, illustrating how human capital can take the form not only of education but also of advanced skills. When asked about the health issues potters encounter, they mentioned back and knee pain, but said that with the introduction of the machinery, the back-breaking work of manual pot making had been greatly reduced.



Participant's in the discussion with potters in Village I.

In Village II, 19 members of a large women's self-help group participated in the discussion. Most were the leaders of specialised 'cells', each of which had its own speciality (e.g. small shops, weaving, basket-making, making small loans). This enterprise, like that of the potters, was started in the aftermath of the 1999 cyclone, during the period of rehabilitation, with VHAJ encouraging women in the community to consolidate their skills in the form of the self-help group. The discussants related that there had been early resistance from village men, but that with time and success, the men came to appreciate the addition to household livelihood that the women were contributing. KI, in addition to serving as my interpreter, pointed out that one consequence of men's tolerance was the presence of the women at our discussion, at about noon, meal time. Traditionally, the women would have been home seeing to the feeding of their families. That these women were present, at ease, and enjoying their participation, was evidence of their empowerment.

The discussion centred on the empowerment aspects of self-help group participation, and also on the effects of participation on the women's sense of well-being. The participants were highly engaged in the discussion, animated in their gestures, and obviously enthusiastic to communicate

how important the group is in their lives. When asked if part of their identity is tied to their group membership, one woman said it had become a dominant aspect of her identity, and the others expressed agreement.



Participants in the VHAI-supported women's self-help group discussion in Village II.

It was revealed that part of the reason for this is the legitimacy of the group with the outside world; not least bank officials who had come to trust the group due to its excellent record of following its business plan and paying back loans on time. This solid business performance characterised the operations of the group. When asked if they had any trouble collecting payments on the small loans they made within the village, they laughed, and assured me that was no problem, that they had ways of being sure that never happened.

Though the main reason the group was formed was to enable economic development and strengthen community capacity to cope with poverty and related challenges, the participants emphasised the social importance of the group. Asked if participation in the group was fun, they responded that having fun together was a major aspect of group activity. The group provides a

refuge from the stresses of the home, where women have to cope with demanding mothers'-in-law and other domestic demands.

During get-togethers with other group members, a woman has the chance to express her frustrations and worries to understanding and sympathetic friends, and experiences some relief from doing so. One woman told of the practical advantages of group membership in enabling recreation – she said that even if a family was too poor to take the time and energy to go on a picnic, the group could pool resources for a group-only picnic.

The atmosphere of the discussion was bubbly, with many women actively participating, several taking at once, and with frequent interruptions by those who could not contain their wish to express themselves. Even after the discussion came to a close, quite a few women lingered, seeming eager to continue enjoying the companionship of the occasion. It was crystal clear that the self-help group was a meaningful and central part of the lives of these women.

Village III was somewhat more remote than Villages I and II, located on a low-lying island around which a river flowed. The only means of access are two river barges, poled back and forth regularly, serving transportation needs from both river banks. After alighting from the barge, the village was reached in a 20 minute walk. The discussion was ostensibly to be with a women's self help group, and took place in a small open temple near the village centre. However, the first participants to arrive were a large group of men, all farmers, who were choreographed by a leader to sit, gathered on one side of the temple floor. After the men were seated a smaller group of women arrived, and they sat together on the opposite side of the temple's floor.

Adjusting to the surprise appearance of the men, the discussion began with the men, as it was clear it had to. The men turned quickly to the overriding aspect of the villager's lives, the annual (and sometimes bi-annual) flooding of the village and its fields, which totally inundate the lowest-lying parts of the island. The only refuge is a man-made hill, a low plateau, constructed by the government for the express purpose of provided high ground for animals, people and essential possessions during times of flooding.

It turned out that the men had appeared for the discussion because they had some idea that VHAI, and I, might be of some help in communicating to the government that they needed help, both with flood control and with land retention.

Trying to turn the discussion back to the intended theme, I asked the men what they thought of the women's self-help group, and many simultaneously expressed approval. They said they were enthusiastic from the start, having heard about the success of a women's group from the men in a neighbouring village. Asked if they could recommend such self-help groups to other villages, they said they had already done so, to two neighbouring villages.

Further probing brought shades of nuance to the story. As it turns out the men were working with a banker to try to arrange a loan, and the banker conditioned the loan on the establishment of a women's self-help group, which he had seen work well in other places.



Men attending and dominating the discussion intended for women only, in Village III.

When I tried to engage the women, they were clearly reticent to speak, and did so in low mumbles and with scarfs covering their mouths. The interpreter later explained that this was to expected, since a women would say nothing in the presence of certain men – her husband's older brother for example – and little otherwise in the presence of any group of men. Thus, the aim of the visit, to engage in a discussion with the women's self-help group, was subverted.

Much was learned however. When asked when the self-help group was formed, and what it intended to accomplish, there was a long silence, then one young woman managed to mumble that it had been established for only the past 18 months, and that so far its activity was restricted to saving money, which it planned to lend and earn interest on. Pressed, none of the women could volunteer information on what future activities the group might focus on, nor what the money earned would be used for.

This part of the discussion had hardly begun when one man – who had been the dominant voice during the discussion with the men -- interjected that the money the women saved and earned would be used to purchase a tractor. No one had anything else to say, and the discussion quickly turned back to the flooding problem. In a flurry of discussion, the men decided to illustrate the problem for us, using sand of various colours to construct a map of the village on the temple floor. I had the impression they had done so before, perhaps as part of a rapid rural appraisal, a development assessment methodology which uses such mapping techniques extensively.

At the end of the visits to Villages I and II, group photos were enthusiastically arranged; no group photo was suggested in village III, and the photo above was taken during the discussion.

Reference Group Meeting

The Reference Group discussion was initially guided by an agreed agenda as shown in Appendix I. The meeting Chair, Alok Mukhopadhyay, opened the meeting by extending a welcome and a thank you to the participants on behalf of the project and VHAI. He then provided a brief overview of VHAI's activities in the coastal region of Orissa during the decade since the super cyclone. I followed with a presentation about the background and aims for the project, which stimulated an overarching discussion, with these key points made (amongst others):

- The benefits of examining positive deviance in health are under-appreciated; there are important lessons to be learned from those with good health. For example, people in very poor ruralities with good health are likely benefiting from a traditional diet in adequate amounts. As one member said 'the local way of eating is best, as long as access is adequate.'
- Researchers have a tendency to oversimplify complex phenomena and model them statically and linearly, when in fact systems models are more appropriate to complex and continuous phenomena, such as the SDH. Complexity was illustrated by considering caste in India, where

couples of lower castes are less likely to engage in sex detection of embryos (leading to selective birthing) than are couples of higher castes. This reverses the presumed relationship between social position and good health and social practices.

- Our work with the social determinants of health should be done in accord with a philosophy embracing participatory approaches, and an emphasis on action for positive change; we cannot be content merely to observe troubling conditions.

Following the opening discussion, the Chair of the first regular session started the work of the meeting with several observations that helped set the frame for the rest of the work (some of the subsequent elaborations on these points made by other Reference Group members are included):

- Inequity in health in India not only persists, it is growing.
- The national level data that are available on the social determinants of health are collected first at the level of the individual and the household, and then aggregated to the state level. However local level data are needed for wise policy making, since conditions vary from locality to locality. It would be quite simple in future to include variables permitting district-level analysis, if not also lower-level analysis.
- Greater consistency is needed in the measurements that are made in serial health and development surveys, so valid comparisons can be made, allowing trends to be followed.
- Aside from the conditions and situations of individuals and households, attention must be paid to the location disadvantage of very poor ruralities, where shared disadvantage is a force on the health of all residents.

On the second day, VHAJ started the day by summarising the work of the organisation in Orissa. During the decade since work commenced, more than 1,000 self-help groups have been stimulated and assisted. While the work began with the focus on emergency relief from the ravages of the super cyclone, it moved on to a rehabilitation phase, and then a planning phase to strengthen the communities' capacity to cope with future disasters. The cyclical and enduring nature of VHAJ's work with the self-help groups was emphasised.

The point was made that enhancing preparedness, coping with the immediate effects of a disaster and rehabilitation, recovery and growth of capacity, are very long term, intertwined activities. Though the initial engagement with the communities was a relief effort, VHAI's work has since also taken on an economic development perspective. At the core is the idea, now well-proven according to VHAI, that self-help groups are a vehicle for economic development, empowerment, the production of social support, and improved well-being of people, both in acute periods caused by disaster and in more normal times as well.

An open discussion followed, in which these points were raised, mostly seeking clarification about the project:

- Time must be taken to address the conceptual issues, examine the premises of the project, and clarify for whom, and for what purpose, the project is being conducted. There is an ethical dimension that leads to a differentiation between 'health research' and 'research for health'; which of these is the aim of this project? We should strive to formulate research questions based not only on academic interests, but on community interests.
- There exists a large body of research on the SDH generated in India, but not well enough disseminated internationally. Means should be found to illuminate this knowledge base in ways that can inform the international collaboration for action on the SDH. Regarding this project in particular, it is highly desirable that the means be found to link the various national components – India, Haiti, Ghana, and the others – horizontally, because the direct connection of the parts will result in a more robust whole.
- Despite the sponsor's mandate that the focus of this project is on very poor ruralities, research with similar aims is badly needed for the benefit of urban areas.
- While attempting to identify fairly universal SDH, it is vital to understand and appreciate that health determinants are textured by local contexts. Efforts alongside the present project are called for, at national, district and local levels, that respond to the imperative of 'health in context'. There is clearly a need for mixed methods research, such as this project is undertaking, in which quantitative and qualitative elements support one another in a synergistic way, not only at the research design stage, but at all stages including data collection, analysis, interpretation and the drawing of lessons and

conclusions. There is also a clear need for action research alongside descriptive research such as this project is undertaking.

There followed a discussion aimed at clarifying and defining a reasonable scope for the remaining work of the Reference Group, with one member noting that upon reflection, he could not think of anything that was not a determinate of health! There was sentiment for a two path approach. One path – that of this project – is to attempt to identify a few key, general SDH, and produce advocacy tools/documents/activities to be used to influence the WHO and other health bodies to take better into focus the SDH of people in very poor ruralities. Another path, perhaps in India to be taken by the members of the Reference Group, is to conduct local, highly contextual analyses and actions that respond to the needs, capabilities, and realities of people where they live.

Quite importantly, the Reference Group emphasises the connectedness between determinants of health fairly close to individuals – financial, material, social, cultural, political – and more remote determinants. Two of these were spotlighted: (1) the need for access to primary health care that is really accessible, really sensitive to the conditions of living of the rural poor, and really responsive to the health and social needs of the rural poor, and (2) macro determinants of health, including but not limited to:

(a) Agricultural and minerals mining policies and practices that lead to unfairly compensated displacement, labour exploitation, unfair pricing and unfair subsidies;

(b) Political and economic conditions that lead to war and conflict, and the exacerbating influence they have on big agriculture and on conflict, which affect the poor the most;

(c) Mega projects such as hydroelectric works that displace and dispossess the rural poor almost exclusively;

(d) Health care financing schemes that drive up costs for those who can least afford to pay for care;

(e) Policies dealing with climate change, energy, which fail to duly consider the extraordinary burden bad policy places on the poor.

Returning to the subject of primary health care, it was noted that the resurrection of primary health care for all is a clarion call of WHO Director General Chen, and that the advocacy work which this

project is intended to support must highlight the vital importance of primary care, even if it is not usually conceived as a SDH.

The Reference Group decided to use its remaining time to consider SDH falling into these arenas: education, social aspects of disaster, gender-based discrimination, a woman's social position in the community, and political capital.

Education

Education is commonly conceived by development researchers as one element of human capital, and its measurement in research is actually a measure of exposure to schooling (completion of levels ranging from primary to graduate). Thus education is a construct separate from knowledge, which together with skills and abilities are also conceived as elements of human capital.

So, while education is an important SDH, it does not capture knowledge, nor does it include forms of education other than schooling that produce knowledge, skills and abilities. Regarding very poor ruralities, evidence shows that schooling completion at levels less than completion of primary education may be associated with better child and adult health, so schooling measures need to be more fine-grained at the lower end if they are to be relevant to schooling in very poor ruralities.

Also, the acquisition of knowledge, skill and abilities in very poor ruralities may only rarely be acquired via schooling, and other forms of education may be much more relevant. These include apprenticeship, and exposure to other community members who provide education in traditional ways. Educated members of households may educate others in and out of their own households, including instruction on topics covered by conventional schooling. Parents and other elders convey a wide range of knowledge to the young via story-telling and the use of parables to teach norms and accepted practices.

If research on education and health is to be relevant to very poor ruralities, conventional measures of education will require adjustment to address the issues raised here.

Social Aspects of Disaster

An appropriate response to disaster and the threat of disaster is not merely relief efforts, but also individual-, household- and community-level preparedness and coping skill-building, integrated into daily life. Examples exist of small groups of people in which none have perished in disasters that took the lives of almost all others living in the same area. The survival edge in these cases is traditional

knowledge about how to recognise impending disaster, and how to cope by taking timely actions of proven efficacy.

For these survivors, in other words, eventual disaster is expected, and preparedness and the honing of coping skills is part of daily life. Since many if not most people living in very poor ruralities are also exposed to the possibility of disaster in its many forms, disaster as a cycle can only be addressed by constant disaster preparedness. This may take the form of traditional education and drilling, or formal education and drilling. Whichever, it is prudent that disaster training and preparedness be integrated into the social lives of people in very poor ruralities, due to the large potential to save lives and reduce injury and disability.

In many rural communities in India, but by no means all, disaster preparedness is an ongoing activity. To track this SDH, researchers should develop brief measures that tap such activities. Simple questions may be serviceable, such as 'Do you have a clear idea about how you will react the next time _____ occurs?'; 'Have you received disaster training?'; 'If so, do you remember enough of it to be confident that you can cope with the next disaster?'

Also, researchers are able to easily assess the degree to which recommended disaster preparedness is a part of daily life, by ascertaining the degree to which these elements are in place: concrete room; wells on raised platforms; roof direction optimal to resist wind; and social groups trained to meet disasters. Social capital in the form of well connected, trusting and supportive networks may be amongst the most effective disaster coping resources. Amongst other effects, cohesive community structure can help prevent the breakdown of a community under the pressure of disaster, natural or man-made.

It was noted that as with so many stressors, disasters may have even worse effects on women than on others, and lack of sufficient preparedness may have harder consequences for women, unless special consideration is given to women's needs in the face of disaster.

Finally, concern with physical safety should not override legitimate concern for the threats to mental health that exposure to disaster entails. Distress and feelings helplessness and hopelessness may endure long after scars are healed, unless due attention is paid to psychosocial rehabilitation.

Gender-based discrimination

“Being a woman can be bad for your health” quoted one member of the Reference Group, as the topic of gender came on the table. It was soon clear that two related topics needed to be addressed: being a woman, and being women living with gender discrimination. As to the former, the trials and tribulations of womanhood came ringing from the Group: conceiving (and trying not to), giving birth (and hoping to survive the experience), caring for others (and neglecting oneself), becoming old and widowed (and lonely and even more vulnerable). With marriage the precursor to all these, one group member said ‘marriage is a risk factor!’ Indeed, just being woman is hard enough, and a life cycle approach to women’s health is essential, even if not realised.

There is, however, an extra dimension of burden to being woman, and that is being the victim of discrimination because of it. The Reference Group dwelt on this subject, noting that a key social determinant of women’s health is her social position in the home, and outside the home (considered in the next section).

Asked, ‘what are the obvious signs in a home that a woman is treated fairly and not the victim of discrimination?’, the Reference Group had six answers:

- The couple shares work, decision-making, money, resources, childrearing, health care
- The couple eats together
- The parents have equal joy over the birth of a girl
- The woman has freedom of mobility, can travel alone
- The daughters can study whatever they want to study
- The couple shares in making contraceptive choices
- There is no domestic violence (sign of affection or not)
- The parents treat their boys and their girls equally

These characteristics are easily measurable in survey research, but are not, even though they quite likely have applicability right across the globe.

The Reference Group agreed that a wide range of factors play into the equation determining a woman's social position in the community, and this is important, since an extraordinarily large body of research shows that social position has an influence on health. Social, ethnic and inherited background, wealth, material possessions, position in the home and many other factors are no doubt in play. Apart from these, the Reference Group identified a handful of indicators that could be considered by researchers wishing to measure women's social position in the community, at least in traditional rural societies with traditions and norms not too different from those of rural India. These indicators predict higher social position in the community:

- Having sought-after skills and being able to impart them to others
- Having sons
- Better yet, being a mother-in-law (e.g., having married sons)
- Being demographically gifted (aged 45 and older)

Political Capital

Political capital refers to having and using the right to participate in decision-making at all levels of society – neighbourhood, community, district and nation. Access to political capital is linked closely to financial, social and human capital. People who are so poor that scrambling for a subsistence livelihood is a daily struggle, are also likely to have little political capital. People living in distrustful communities, where social ties are weak and networks are small or dysfunctional, and people who cannot read well enough to follow political debate, or have no access to mass media, are also likely to have little political capital.

This is why the right to vote does not translate into voting, let alone taking part more actively in political processes. Political capital may also be manipulated directly, as in non-democratic societies, and indirectly, as when authorities restrict access to information and education. However political participation has other faces than voting and holding office. Supporting and participating in civil society organisations that work for social change at levels from local to international are powerful expressions of political capital.

An example of such community voices in India is the movement around the People's Health Charter. Involvement in the development and implementation of Village Health Plans is another example. Political capital has at least two dimensions, the individual and the community. At the individual level and with regard to political participation in general, many measures are already in use in social surveys (the European Social Survey, for example), if not in health surveys, so good models exist for health researchers who wish to measure this aspect of political capital.

At the community level and with regard to health in particular, the issue is more the degree and tone of political action, and few suitable measures exist so far as we are aware. However it is not difficult to imagine how such measure might be expressed: 'Is health discussed as a political issue in your community?' Is your community acting in a way that shows health to be an important issue?'

Concluding Remarks of Reference Group Members

At the conclusion of the meeting, a number of Reference Group members wished to emphasise certain points, and these are listed here:

- Data are needed at the local level, to support action at the local level. Current survey systems in India and elsewhere do collect data at the local level, but aggregation of data to state or higher levels obscures these valuable local data.
- In India, caste and tribe remain powerful determinants of health and must be considered in any Indian analysis of the social determinants of health.
- The present project will be substantially enhanced if ways can be found to link its (country) parts horizontally.
- Two topics of great importance in very poor ruralities are the need for quality health education, and need to factor disaster preparedness into the consideration of SDH.
- In the search for solutions to the lack of adequate primary care in very poor ruralities, it is wise to look to public-private partnership as an innovative model, following the lead of VHAI and other agencies.

Appendix I. Reference Group Meeting on the Social Determinants of Health
on 16-17 April, 2009 in Bhubaneswar, Orissa, India: members, agenda and minutes.

	Participants
1.	Mr. Alok Mukhopadhyay Chief Executive, VHA, New Delhi IUHPE Board Member, Head, Reference Group, Southeast Asia
2.	Prof. Maurice Mittelmark Professor and Director, Research Centre for Health Promotion, University of Bergen, Norway, IUHPE Board Member Project Director
3.	Dr. L.M. Nath former Director, AIIMS
4.	Dr. Ashok Dayalchand Director, Institute of Health Management, Maharashtra
5.	Ms. Indu Capoor Executive Director, Chetna, Ahmedabad
6.	Dr. Thelma Narayan Executive Director, CPHE, Bangalore
7.	Dr. Prakash Tyagi Director, GRAVIS, Rajasthan
8.	Ms. Sreepana Ghosh RRC Coordinator, CINI, West Bengal
9.	Mr. Loknath Mohanty Executive Director, Orissa VHA
10.	Dr. Almas Ali Consultant, Population Foundation of India
11.	Dr. B.B. Rai Executive Director, Sikkim VHA
12.	Ms. Itishree Kanungo Senior Manager, Aparajita Orissa, VHA
13.	Mr. Shishir Ranjan Dash Senior Manager, Aparajita Andamans, VHA
14.	Ms. Anjali Gupta Sr. Programme Officer, VHA

Reference Group Meeting on Social Determinants of Health:

IUHPE Project on the Social Determinants of Health in Very Poor Ruralities

Venue - The New Marrion, Bhubaneswar

Address - 6, Janpath, Unit-III, Bhubaneswar- 751001, Orissa

Agenda

16 – 17 April 2009

Time Frame	Event/Subject of Discussion
<i>16 April (Thursday)</i>	
8.00 – 10.00 a.m.	Guided Tour for nearby local sightseeing (<i>optional</i>)
11.00 a.m. – 12.00 p.m.	Health Agenda for the New Government of India
12.00 – 12.30	Lunch
12.30 – 1.00 p.m.	Welcome, Introductions <i>Alok Mukhopadhyay</i> , Chief Executive, VHA Head, Reference Group, Southeast Asia
1.00 – 2.00 p.m.	Overview of project, Role of Reference Group, Goals of the meeting <i>Maurice Mittelmark</i> , Professor and Project Director, Research Centre for Health Promotion, University of Bergen, Bergen, Norway
2.00 - 2.30 p.m.	Response from the Participants
2.30 - 3.30 p.m.	“All politics is local”... is all health local, too? The limits of international and national-level data on the social determinants of health, in understanding health at the <u>local</u> level. A Roundtable Discussion <i>Chair - Alok Mukhopadhyay</i>
3.30 - 5.00 p.m.	Health in very poor ruralities -- lay concepts of what it means to have <u>good</u> versus <u>poor</u> health. A Roundtable Discussion <i>Chair - Maurice Mittelmark</i>

5.00 p.m.	<i>Evening Tea</i>
5.30 p.m.	Departure for nearby local sight seeing - Dhauli
Time Frame	Event/Subject of Discussion
<i>17 April (Friday)</i>	
9.00 – 11.00 a.m.	<p>The social determinants of health in very poor ruralities, with the married woman of child-bearing age in focus. Which determinants are common across the region?</p> <p>A Round Table Discussion</p> <p>Chair – <i>Dr. Ashok Dayalchand</i>, Director, Institute of Health Management, Maharashtra</p>
11.00 a.m – 12.00 p.m.	<p>What determines the social position of married women of child-bearing living in very poor ruralities? Position in the household.</p> <p>A Round Table Discussion</p> <p>Chair – <i>Ms. Indu Kapoor</i>, Executive Director, CHETNA</p>
12.00 – 1.00 p.m.	<p>What determines the social position of married women of child-bearing living in very poor ruralities? Position in the community.</p> <p>A Round Table Discussion</p> <p>Chair – <i>Dr. Thelma Narayan</i>, Executive Director, CPHE, Bangalore</p>
1.00 – 2.00 p.m.	Lunch
2.00 – 3.00 p.m.	<p>What determines of the social standing of households within the very poor rural communities of which they are a part?</p> <p>A Round Table Discussion</p> <p>Chair – <i>Mr. Shisir Ranjan Dash</i>, Senior Manager, Aparajita Andamans, VHA</p>

3.00 – 3.30 p.m.	Tea Break
3.30 – 4.30 p.m.	<p>Coming full circle – Summary Discussion of the Social Determinants of Health in very Poor Ruralities. What should be measured?</p> <p>A Round Table Discussion</p> <p>Chair – <i>Dr. L.M. Nath</i>, former Director, AIIMS</p>
4.30 p.m.	<i>Evening Tea</i>

Minutes of the Reference Group Meeting on the Social Determinants of Health
on 16-17 April, 2009 in Bhubaneswar, Orissa, India

Day – 1

16 April 2009

Welcome, Introductions

Mr. Alok Mukhopadhyay, Head, Reference Group, Southeast Asia & Chief Executive, VHA started the day's deliberations with an introduction to the programme, explaining the purpose of the collaboration. He emphasized the following points:

- Health is not an expense but an important investment – for the economy and the country.
- In India there has been great understanding on the social determinants of health and considerable work has been done. However the practitioners of public health have not looked at the social determinants of health in details at the grassroots level. There is a disconnect between the academic and evidence based work at the grassroots. It is important to have evidence based outcome.
- He stressed on the need of a dialogue with the new Government on the performance of various health programmes.

Introductions

This was followed by the Introduction session. Each participant shared in brief his/her area of functioning and expertise.

Overview of the Project, Role of Reference Group, Goals of the meeting

Prof. Maurice Mittelmark, Project Director & Professor, University of Bergen, Norway presented an Overview of project, Role of Reference Group and the Goals of the meeting.

Comments from the Participants

- Dr. L.M. Nath, former Director, AIIMS and Consultant, VHA raised the following concerns emerging from the presentation by Prof. Mittelmark
 - Choice of end points as static end points is not correct like immunization coverage. To assess the health impact it is important to look at the process since several factors are a part of the continuum. It cannot be considered as a static model.
 - It is important to learn from positive deviants. A multi-variate analysis is not enough.

- The model is in too many cases static, should have been dynamic.
- Dr. Ashok Dayalchand, Director, Institute of Health Management, Maharashtra stressed on the need of inclusion of health behaviour. He also expressed the desire to be made better aware of the project goals and expected outcome.
- Ms. Indu Capoor, Executive Director, CHETNA, Ahmedabad mentioned that in India one of the most important aspects is caste and its connection with the religion. Other important determinants are access to food and nutrition related diseases.
- Dr. Thelma Narayan, Executive Director, CPHE, Bangalore stressed on the need of focusing on social behavioral and strength based approach.
- Based on his field level experience with a policy perspective Dr. Prakash Tyagi, Director, GRAVIS, Rajasthan stated the need to link with health spending. In India despite poverty the poor villagers spend on chronic illnesses. Also the human capital aspect must be included since in our country often the available resources are not fully utilized.
- Dr. L.M. Nath shared that in India there is a tradition of oral learning methods. The health system of the country involves use of local traditional medicines. The blood pressure measurement technique is not present in all medicine systems like the Tibetan medicine. While measuring 'Who is Healthy' it is important to include parameters like happiness, contentment.
- Prof. Mittelmark clarified that he has used in his presentation the traditional epidemiological approach to community health. Regarding the query about immunization as static end point, he mentioned that it was not considered as an end point but was with a query as what lies behind that. The presentation has not covered all the factors suggested but there was an effort to simplify it. He agreed that the some of the suggestions like the inclusion of nutrition aspect and oral tradition methods in India need to be included.

Post Lunch Discussion

- Dr. Almas Ali, Consultant, Population Foundation of India chaired the session. He mentioned that in India the Sample Registration System for enumeration of health and development data was started in 1971 and since then there have been significant improvements in various health

and development indicators. Despite this overall improvement in the health indicators there is huge disparity in the health indicators across the country. As SRS is a state based analysis of the health and development indicators, till 1988 there was no district level information available. District Level Health Survey (recently renamed as District Rapid Health Survey) (DLHS) was initiated in 1988 and the second DLHS was done in 2002 and the third, i.e., the latest in 2007-08. He stated that these are mere paper exercises and the various available data figures lead to confusion and cannot be considered reliable.

- Dr. Ashok Dayalchand agreed and added that the validity of the data is also questionable.
- Mr. Shisir Ranjan Dash, Senior Manager, Aparajita Andamans, VHAJ based on his field experience during the Microdis survey, stated that many aspects cannot be covered in any static exercise and without the involvement of the community perspective these statistical information has less meaning.
- Ms. Indu Capoor stated that any research without action is nothing but an exploitation of resources.
- Dr. Ashok Dayalchand raised following queries
 - What is the expected outcome of the workshop
 - Each component of the suggested framework needs to be operationally defined in Indian perspective.
 - Many Indian aspects are missing from the proposed model
 - Huge amount of qualitative information is required to add to the findings of multivariate analysis.
- Mr. Alok Mukhopadhyay mentioned that the theory of Social Determinants of Health is not a new theory and there was a huge expansion of CSDH in WHO. One of the major issues which emerged was that it was not a prescriptive report. It was realized to capture other aspects of health in a global forum. Also at the country level it is important to bring out our accumulated knowledge and experience and put it together in an internationally acceptable format/lingo.

There is a need to enumerate information besides the government surveys. VHAJ has recently conducted a survey in Orissa where besides the qualitative information we collected lot more details through qualitative tools like Focus group discussion with women folk.

- Mr. Shisir Ranjan Dash suggested that the community should be consulted before framing the questions.
- Dr. B.B. Rai, Executive Director, Sikkim VHA mentioned that the social determinants are different from region to region. Accessibility may not be the important concern but connectivity matters in hilly regions
- Dr. Thelma Narayan suggested a study to be conducted for Malabasi where there is hardly any case of low birth weight baby. Documenting the process at community level is the best way to show. This can perhaps show the path way. She also challenged the statement ‘all politics is local’ rather it is global. Like the agricultural policies at an international level impact the agricultural economy worldwide. In such a situation global policies victimize the local level and there needs to be some accountability of this.
- Mr. Mukhopadhyay stated that this kind of study is only done in India in the South Asian region. We need to become an active partner with sufficient engagement in the study. 20th IUHPE World Conference on Health Promotion during 11-15 July 2010 in Geneva, Switzerland may be another forum where recommendations of this project will be showcased and shared.
- Dr. Ashok Dayalchand mentioned that based on the discussion some of the emerging concerns are the need to develop an operational definition; possibility of pursuing a multi-centric study and the framework can be defined.
- It was felt by the participants that there should be a partnership with the University of Bergen on this project of mutual interest and to get the Indian perspective into a global lingo/framework.
- Mr. Mukhopadhyay mentioned that besides this as an active group of NGOs in the current political scenario of the country we need to present the CSOs’ voice collectively to the new government in India.

The day ended with a note of thanks to the chair, panelists and the participants for the stimulating discussion.

Day 2

17 April 2009

- Mr. Alok Mukhopadhyay discussed the following concerns:
 - Conceptual research issues need to be addressed
 - Ethics of research like for whom, objectives and methodology need to be clarified
 - If it is a cross country global research experts from different sectors will be required. That marks the need of a cross cultural dialogue and a horizontal integration.

He emphasized the need to resolve these issues.

- Mr. Loknath Mohanty, Executive Director, Orissa VHA shared the initiatives of their organisation Orissa VHA. The organisation is into various developmental projects like health and sanitation, tobacco control, community mental health, capacity building of youth amongst others.
- Mr. Shisir Ranjan Dash briefed about the grassroot development initiatives of Aparajita-VHA in Orissa since 1999.
- Dr. Thelma Narayan mentioned that there is much scope to take the grassroots concerns forward. There should not be any conglomeration rather focus should be on diversity. There exists a need to clarify the process indicators and the goals.
- Dr. Ashok Dayalchand stated that the social determinants are different among the urban and the rural areas. This needs to be considered. It is important to have a multivariate model since the indicators used in Jamaica may not be applicable in India.
- Ms. Sreepana Ghosh cited an example of a delivery case where in spite of the accessibility and availability of medical delivery services, the family did not opt for them and the delivery took place at home and the child died within twelve hours. These issues as what compels such behavior also need to be addressed. NFHS – 3 data has been used in the presentation where the

data does not take note of such situations and thus are not true reflection of the health situation of the ruralites.

- Mr. Shisir Ranjan Dash mentioned that the Indian context is value based and therefore the framework should be locally modified and adaptable.
- Dr. B.B. Rai stated that in a country like India, social determinants of health vary region to region. Like in the hilly areas connectivity is a big concern. Thus the social determinant indicators need to keep the region consideration in context and can identify common indicators as well.
- Dr. Thelma Narayan opined that the grassroots does not have a role to play in the policy formulation despite the effect it has on them. She felt that linear model could be perhaps used in order to capture the processes with an understanding of what they are trying to change. There needs to have some clarity about the objectives of the research.
- Prof. Mittelmark responded that the project document is not a research paper but more an advocacy tool to illuminate the work of Commission on Social Determinants of Health. The main justification for the focus on poor ruralities is due to the priorities of the funding agencies since the poor rural inhabitants are considered to be more affected.
- Dr. Ashok Dayalchand felt that the research outcome should have direction for an action project.
- Mr. Alok Mukhopadhyay requested Prof. Maurice to reflect upon if there is any possibility of the incorporation of suggestions from the group in the project document/concept. However he stressed that the suggestions from the esteemed group will further strengthen the study.
- Dr. Ashok Dayalchand emphasized that since the project is an advocacy tool more than a research project, it is important to assess there are enough funds to involve the Indian group at a global level. Followed by this the second level of advocacy will be at the state and local level.
- Prof. Mittelmark stated that the present members have expressed the desire to be actively involved in this project on Social Determinants of Health. Some of the important issues which

need to be included in the project are, social position, gender, disaster related indicators. There could be perhaps more issues.

- Mr. Alok Mukhopadhyay remarked that there is scope to develop the concepts as well as the premises. He requested the participants to send their feedback. If the project is not having enough resources the group can try to look for resources as the opportunity should not be lost. A suitable mechanism which can be dovetailed with the project of Prof. Mittelmark can be figured out.
- Mr. Alok Mukhopadhyay further shared with the participants that the theme of the forthcoming issue of VHAJ journal Health For the Millions is 'Social Determinants of Health.' The issue is having Ms. Mirai Chatterjee as the Guest Editor and will be having article from Sir Michael Marmot. Articles from the present group of public health experts would give a positive critique and a way forward to the entire subject. This issue of the journal would be perhaps shared with the new government.
He further stated that Prof. Mittelmark should see if there is any possibility of including a horizontal dialogue in the project.
- Dr. L.M. Nath stated that CSDH has done an initiation and all such efforts show a way forward. Corollary of this is – the analysis and paradigm that have been discussed thus far need further refinement as they come from a certain level of development – so they need to be modified from a developing country perspective.
- Mr. Alok Mukhopadhyay agreed and stated that there is a lot of scope for the further refinement of the project. The ethical aspects of research must be included and there exists a need for a horizontal discussion at a global level since the voice from developing countries like India is often not heard in the various global forums.

Post lunch Session

- Ms. Indu Capoor stated that besides the gender and other macro indicators, the nutrition related indicators should also be included.
- Some other issues suggested by Dr. Tyagi and Mr. Shisir were disaster management and preparedness since in case of any stressful situation poor are the worst affected.

- Dr. L.M. Nath remarked that the vision of the agenda is important and there is a need to look beyond the report. It should not only rely on the national data but should take a note of the local situation.
- Prof. Mittelmark confirmed that he will take forward the concerns shared in the meeting with IUHPE, since it is their project. He profusely thanked the esteemed group of public health experts from various parts of India for the active participation, stimulating discussion over the theme and having offered a critical viewpoint.

Chapter 5. The Ghana Field Visit, April 2009

Torill Bull

Overview of activities

The field visit to Ghana was conducted by a group of three persons. Torill Bull, SDHVPR project coordinator, travelled together with two Master students from the International Master's Programme in Health Promotion at the Research Centre for Health Promotion, University of Bergen. One of these students, Mary Duah-Owusu, is a Ghanaian from Accra and had an important role as a door-opener, translator, and advisor in practical matters. The other student, Crystal Autry Andvik, has previous experience from working in Western Africa and will be writing her Master's thesis analyzing the qualitative data collected during the field visit. Both students took part in the field trip as part of their study programmes. The total duration of the visit was 10 days. Most of this time was spent in a poor rural community in Northern Region of Ghana, where a local NGO (Northern Empowerment Association, NEA) were our facilitators and kind hosts. The programme for the 10 day visit to Ghana was as follows:

Day 1

We arrived in the capital Accra in the evening.

Day2

This day was spent looking around Accra and preparing for the trip to Northern Region.

Day 3

We travelled to Northern Region by bus, a journey of approximately eight hours. After arrival in the early evening we had our first introduction to the NEA project base in Carpenter, Bole District, where we also had accommodation during the visit.



1. From the NEA base in Carpenter. 2. Happy women at completion of the 3-year groundnut programme

Day 4

This day was spent at the NEA project site. We planned the research in meetings with NEA staff, including discussion of interview guide and translation issues. NEA provided us with two local translators. The interview guide was piloted in a meeting on site with 50 women from various women's co-operatives who were gathered to receive husbandry education in connection with their 'examination' after three years in the groundnut programme. We were present in a meeting where the women received health education from a doctor from the nearest health clinic. We also had the pleasure of watching the formal 'examination' of this group of women from the groundnut programme, seeing them breaking into spontaneous singing and dancing after receiving the money to buy a goat. In the afternoon we made an interview with Brenda Mensah, learning about NEA activities and history.

Day 5

This day we travelled to a village in the area, in which we had interviews with two groups of women who were part of the groundnut programme. During the rest of the day, and every other day during our stay in Bole, much time was spent in informal information gathering during meals and daily activities. We had meals with the NEA directors every day, thus spending hours learning outside the formal interview settings.

Day 6

This day we travelled to a second village and had interviews with two new groups of women from the groundnut programme. We were also taken on a trip to have lunch by a beautiful waterfall. In the afternoon we were taken on a tour of NEA activities. Informal information gathering went on as before.

Day 7

This day we had in-depth key note interviews with David and Brenda Mensah (interviewed together) and with three young persons from NEA staff (interviewed individually). We also visited a groundnut plot.

Day 8

This day we returned to Accra by bus.

Day 9

We spent this day in Accra, seeing both rich areas and the slum.

Day 10

Return to Bergen.

Summary of observations

Financial and material capital

A person's income in monetary value is important even in economies based on diverse livelihood activities. In addition to giving access to food and health care, having an income increases a woman's status in the village and may influence her status within marriage.

Ownership of objects of very basic character can be of great importance, as is animal ownership.

Indicators should reflect local conditions when it comes to type of animals and type of objects owned. Wealth indices developed for developing countries are inappropriate in poor rural Ghana.

Food security is one of the major influences on the health and wellbeing of women in poor rural Ghana.

Physical capital

Access to clean water and enough water is important; as is the amount of time and effort a woman has to put down to fetch enough water for the family needs. Sanitation is important, and latrines improve conditions. Accessibility of health care facilities is essential and is determined by distance to facility as well as by availability of appropriate transport. Distance to a market is another structural factor that makes a difference.

Natural capital

In this specific rural area drought preparedness was important. Drought preparedness could be influenced by diversification from subsistence farming. Drought-resistant animals like goats were important, as was income generation through various opportunities for cash labour. A diet based on varied sources, including fish from fish ponds, was also a protective factor in case of drought.

Human capital

The balance between work and rest for women was an important predictor of wellbeing. Being hardworking was fundamental for a woman to gain respect, and hard work was thus both a threat to and a protector of the wellbeing of women. The education of women was important, but an educated woman's status did not increase in a man's eyes until he had education at a high level himself. Informal education through participation in groups increased status and resources of women. This participation increased the self confidence of women and built their capacity to advocate for their own needs and the needs of others in the community. Health education, especially on family planning, was an important factor. This education had to reach men as well. Exposure to mass media was a two-edged sword, changing traditions in both positive and negative directions. Giving birth to children was important for the status and wellbeing of the women, but they wished for a limited number of children to be able to educate them and care well for them. A high number of children represented a threat to the wellbeing of women. Girls were increasingly valued and educated. Satisfying basic needs such as food, survival and the capacity to work were dominant reasons for happiness.

Social capital

Level of community support varied between villages. Community support was an important protective factor in times of need, such as if illness or death struck, when moving to a new place, or when seasonality or shocks increased work burden. Time spent with friends was limited by work demands, and men had more time to spend in social interaction with friends than women. Respect and good treatment from husbands was an important protector of the wellbeing of women. Being a widow or divorced put the women at risk of increased poverty and of being ostracized. Family patterns were changing as a result of exposure to media, and this was seen as both a threat and a protector of wellbeing. Generally there was a feeling that social support was diminishing due to general resource scarcity and an increased wish for independence and individuality.

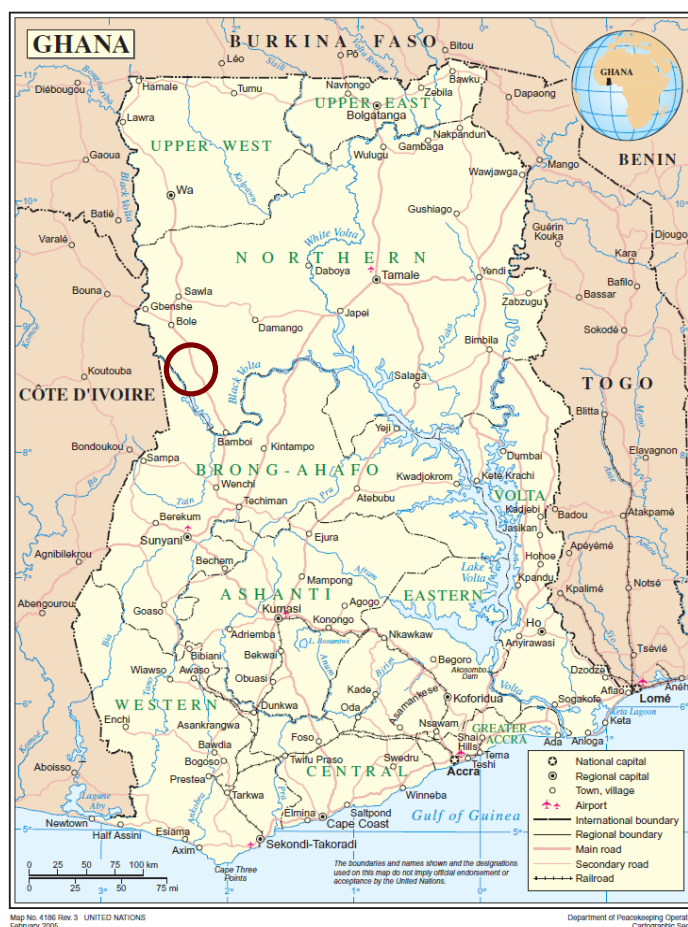
Cultural capital

Religion was reported as an important factor influencing the health and wellbeing of women. The Traditionalist faith was said to increase poverty and fear and held many taboos, which generally were to the benefit of men. Such taboos kept women and children away from important resources, for instance protein sources. Women could also be accused of being witches and ostracized from community. The Moslem and maybe particularly Christian traditions in the area led to an increase in the respect for women, and an increased access for women to resources. Modern attitudes also reduced practice of for instance female genital mutilation.

Political capital

Good leadership was reported to influence living conditions and social coordination for improvement. Such leadership could be found at both the village level through chiefs, at the district level through the district assembly members, and at the district level through the paramount chief. In the Bole district this had led to important changes in cultural practices, strengthening the prerequisites for health in the local region.

Introduction to Ghana and Northern Region



Map of Ghana, Area for field visit encircled (Source: UN website).

Ghana is a sub-Saharan country with a rich cultural history. In rather recent history, Ghana was known as the colony 'The Gold Coast', part of the British Empire. The country was the first on the African continent to gain independence from colonial rule, in 1957. The last decades have seen a good development in the country when it comes to democracy as well as financial development.

On the Human Development Index ranking Ghana is number 152 of 182 countries globally (2003)². The country has a rural population of 54%, a life expectancy of 58.5 years at birth (2005/6), an under-five mortality of 112 per 1000 (2004), and a maternal mortality of 214 per 100 000 live births (2000)³.

² UNDP website for Human Development statistics <http://hdr.undp.org/en/statistics/>

³ Information from WHO country briefs on Ghana, Ghana Human Development Report 2007, and UNDP website for Human Development statistics <http://hdr.undp.org/en/statistics/>

Ghana consists of ten political regions. An important characteristic of Ghana is the strong divide between the developed South of the country and the poorer, less developed North, which consists of the three regions Upper East, Upper West, and Northern Region. This divide has been explained by various factors, including climate and nature, with the South being lush and the North having dry savannah climate, poor soil quality, and washing of nutrients from the ground due to torrential rains. The divide has also been explained in political terms, with a neglect of the area in colonial times which has continued into the post-independence era. Administration and business is located in the South of Ghana, and the North has not had its share of the expanding export business which has been important for growth in the Ghanaian economy. The North has also been troubled with tribal wars between local chieftaincies.

This divide has left the North of Ghana with considerably worse living conditions and with considerably poorer health statistics than the South. In 2000, 70 % of the North was considered poor. Especially the very poorest parts of the North are lagging behind in development and health, and food crop farmers are considered to be the very poorest. Health care is also underdeveloped in this region of the country⁴. The area is scantily populated with a population density of 31 per km². Tamale is the regional capital.

The field visit was done to one of the least developed areas of Northern Region. According to one of our key informants, this area is particularly underdeveloped as it seems to be on the outskirts of everything: belonging to Northern Region, but very remote and too close to the border to the South, thus falling between several chairs. This is the so-called 'Madrid effect' – the further a place is from the capital or political power centre, the worse it fares when it comes to resource allocation. Bole district is situated in the extreme south-east of Northern Region. People in the district are food crop farmers, thus constituting one of the most vulnerable population groups in Ghana.

⁴ Ghana Human Development Report 2007



This picture shows one of the villages in which we interviewed women. Notice the well-swept ground outside the house. The women take pride in keeping their compounds well.

Establishing contact with the case for the field visit

On the basis of the information given above, we considered the North as the most suited region for researching poor ruralities in Ghana. We therefore started investigation of potential partners in Ghana. Online searches based on the regional capital of Tamale made us aware of an NGO called Northern Empowerment Association (NEA)⁵. The information on the website of this organisation made us interested in establishing contact, which was done by email. A cooperation was formed which proved to function to the satisfaction of both parties. Prior to the field visit, details were prepared through email communication. We also read literature from the region, including an informative autobiography⁶ of the NEA founder Dr. David Mensah, describing his boyhood growing up in a poor rurality in exactly the geographical area of our field visit.

Northern Empowerment Association provided us with practical support during our weeklong stay in the Bole district. They organised the group interviews in the villages, and they gave advice on cultural matters and on how best to communicate with the local women.

⁵ <http://grid-nea.org/>

⁶David Mensah (1998). *Kwabena: An African Boy's Journey of Faith*. Canada: Essence Publishing. Available from Amazon.co.uk

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 organisations 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.⁷ 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 activities⁸, and the funds NEA manages to raise this way are matched by the governmental Canadian International Development Agency, CIDA⁹. 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 work¹⁰. 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)

Our field visit in Ghana lasted 10 days, whereof six were spent on site in the Bole district. The main focus of our data collection was the women's co-operatives in the NEA groundnut programme. We also interviewed key informants recruited among NEA staff.

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

⁷ Dr. David Mensah completed a PhD on the topic 'Environmental Ethics'.

⁸ Ghana Rural Integrated Development (GRID). See <http://grid-nea.org/>

⁹ <http://www.acdi-cida.gc.ca/index-e.htm>

¹⁰ More about these NEA activities at the NEA website <http://grid-nea.org/>

women are invited to take part in the groundnut programme which runs over three years. They are organised 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. They are also given 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.

Methods

For the group interviews with women in the villages, an interview guide was developed before we arrived in Ghana. This interview guide, which is found in Appendix I, was based on the women being asked to look at a textile picture depicting two women who were said to be living in the same village, both having a husband and three children, but one being happy and healthy, the other one feeling weak and sad. The women were then asked what could be the reasons why these women felt differently. Our intention with this approach was to elicit information about reasons for doing well despite the general poverty experienced in all the villages. We discussed this approach with NEA staff and got clearance to try it. On the Tuesday of our visit, we piloted this approach in the meeting of around 50 women who were gathered at the NEA site. The experience from this meeting led us to change our approach: Most of the women were obviously confused by the concept of comparing the two women who were not real women. The weak woman in the textile picture was portrayed as sitting on the ground, and several of the women suggested her problem was 'being lame'. In discussion with NEA staff after the meeting, we agreed that the abstract thinking required in our approach was not suitable for these women, as they were mostly uneducated and led an everyday life that honed their skills in very down-to-earth, practical thinking and decision-making, rather than abstract thinking. Our next version of the interview guide was far more concrete, asking about routines and experiences in their everyday lives, focusing on the women themselves rather than on imaginary women. This also changed our interviews with the women in the villages from being focus groups, with a discussion about a theme, to being group interviews with a focus on experiences. The final interview guide is found in Appendix II.

Our informants in the villages were women's co-operatives. These women were taking part in the NEA groundnut programme, and were comfortable being in the group setting. To take part in the groundnut programme they were recommended from the village as the women who needed this support the most. Several were divorced or widowed, with the responsibility of providing for families. Asking NEA staff about whether these women were poorer than most women in the villages, the response was that initially they would have been poorer, but the groundnut programme might have helped them so they were now not necessarily poorer than other women. The women's co-ops normally counted around 20 women, at different stages of the groundnut programme. It would be a problem not including everyone in the interviews, according to NEA staff. We therefore



set up two consecutive groups each of 10 women in each village. This worked well except from in one instance, where a group of women 'stormed' the group in their eagerness to be interviewed. We let them stay, and this group ended up having around 20 participants. This did in no way hinder the free flow of communication in the meeting, but as a result of limited time, all women did not have an opportunity to express their views.

NEA staff made arrangements with the women's co-operatives for the interviews and accompanied us to the villages. Seating arrangements were set up outdoors, under large trees. The women provided us with plastic chairs, while they themselves sat on wooden benches. All groups had provided a table for us to put our recording material on, and the tables were covered with clean cloths. Children were running about playing during the interview, occasionally contacting one of the mothers, but this was not felt as a disturbance for the interviews. The atmosphere seemed very relaxed. Men were not present, except for in one instance where a very calm, seemingly retarded man hung around for some time. We asked the NEA staff present (the translators) whether he would hinder the women from speaking freely, and the answer was negative. To warm up the groups, we told them about ourselves and our families, we and also passed around photographs from our families and our home country. This was really an effective way of establishing contact and goodwill.

The interviews were performed with translators. The women spoke the local language. Well-educated NEA staff from the local area translated. We made audio-recordings with cassette recorders and digital mini-disc recorders. In addition to this Mary Duah-Owusu took notes. Her

Ghanaian background made her able to partly understand the local language of the women, and in other instances she took notes based on the translators. Crystal Autry Andvik took notes on context, such as body language, moods and incidents during the interviews.

Afterwards audio-recordings were left with a different NEA employee for transcription and translation from the local language into English. This employee had previously translated the New Testament from English into the local language and was considered very well qualified for the job.

The women in the groups were given oral information about the project and gave oral consent to participate, and the translators signed forms confirming that the women had been informed before giving consent to being interviewed. This process was recommended and approved from the relevant institutions in Norway who gave ethical clearance for the field visit. We also applied for ethical clearance from the relevant authorities in Ghana.

At the end of the meeting, the women were given some very simple gifts for investing their time in sharing their experiences with us. These gifts were silk dress flowers, bracelets, and postcards from our home town. All gifts proved popular, and the women expressed joy in being interviewed.

Key informant interviews

The individual interviews were performed at the NEA project base, using the same approach for recording and note taking as in the group interviews. These interviews were done in English, as the interviewees were all fluent in English. We did the transcripts for these interviews ourselves. David and Brenda Mensah were interviewed as a couple, in addition to one individual interview with Brenda Mensah. It is hard to protect this couple's anonymity due to their roles, and this situation was discussed with them. They defined this as not being problematic.

The three key informants from NEA staff, two females and one male, were all in their twenties. Two had grown up in the villages from which we interviewed women, and the third had grown up in a similar context not very far away. All had received education beyond secondary high school. The key informant interviews with the NEA staff focused on the same themes as the group interviews in the villages, but with a more thematic and abstract approach. Written informed consent was used with the key informants. In the result section, these key informants are referred to as KI-1, KI-2 and KI-3.

Informal talks and observations

During the entire week in the Bole district, we spent many hours in conversation especially with NEA directors David and Brenda Mensah, with whom we shared long meals daily. Field notes of our experiences and observations during the stay were made on a daily basis, including interesting information obtained through our informal talks with people.

Results

Financial and material capital

The groundnut programme was intended to build the resources of the most vulnerable women. When interviewed, the women reported they had made money that helped them in various ways. One had built herself a house, some provided for their parents and children alone, some reported being able to educate their children and to pay for health care and health insurance. This report is from a woman who had been very successful in the programme:

“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. The following year, I was given money for ploughing. I used the money to hire my son for that work. My son also bought a goat with the money and I know the goat will help him well. The program has helped me”. (Woman)

This citation shows how a small cash income well used can provide a woman with an increased financial security for her lifetime and also enable her to provide in a substantial way for her extended family.



Proud woman in front of a house she has financed herself through farming.

Getting a good harvest of groundnuts depended on several factors. Drought would destroy the harvest. Also illness which reduced work capacity was a severe threat to the income from the farm. Some women described how divorces had forced them to move and neglect their farms for some periods, leading to pests taking over and ruining income.

Having an income of her own changed the women's status with her husband and other men in the village. David and Brenda Mensah described some of the intention behind the income generation work this way:

"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 (...). 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". (David Mensah)

According to information on the NEA website, before they participate in NEA's cooperative program, women earn on average \$20 per year. But women who participated in the co-operative program earned an average of \$360 at their last harvest. This confirms that there is variation in 'person poverty' even within poor places with a general 'place poverty', and that the person poverty is of importance.

Material possessions



Within the very poorest ruralities, the most basic material items to own can make a difference. The woman in one of the citations above described which difference it made in her ability to earn a living to have been able to buy an aluminium pot for brewing. Other goods of importance were a decent cloth to make a dress (see picture to the left – groundnut farmers in their dresses). One of our key informants described a pretty cloth to possibly be higher on the list of priority of the women than procuring shelter, as it was so strongly connected to a woman's dignity.

During this field visit we made the observation that there is lack of appropriateness in using wealth indices including items like cars, refrigerators and other expensive items when doing research within small poor areas. Also flush toilets, piped water and electricity are so rare in these areas that they do not make appropriate items in a wealth index. Only a few percent of people in the area we visited have access to such luxury. Measurement of financial and material status within very poor, rural areas thus cannot make use of the common Wealth Index from many of the DHS surveys¹¹, but must collect information on ownership of items of relevance in the very poorest settings.

From our observations it also seems to make sense to include measurement of animal ownership. This is included in some DHS questionnaires but not in all. In the Bole district, ownership of a goat could make a great difference, being called 'a savings account'. In other regions other types of

¹¹ DHS for some countries have included items more appropriate for the very poorest areas, like owning a chair, a sofa, a cupboard etc

animals may have a greater economic importance, like for instance the alpaca in the higher Andes regions of Latin America.

Food security and nutrition

Life in the villages revolved around securing food for the day. The diet was based on carbohydrates, with very poor intake of protein and micronutrients. Food shortage was not uncommon. During periods of drought existence was threatened. Also, the diet being of poor quality, resistance to disease was reduced, and also the capacity to do hard physical work under the scorching sun.

"When [you] wake up in the morning, you panic because you think of what you will eat".

(Woman)

The NEA programmes had a strong focus on increasing protein intake in the region, through rearing of meat (small ruminants) and construction of fish ponds (see pictures below). The fish project is highly successful, and the plan is to construct fish ponds in every village.



(1) Fish pond at the NEA project site, (2) fish ponds being constructed for increased access to protein, (3) aquaculture in the dry rural savannah has proved to be very successful!

Another factor influencing poverty and nutrition is idol worship:

"(...) part of the poverty in this area was also due to severe, severe practice of idol worship. One of the reasons why I think most families are poor, is that they will have say, five-six goats, but then this idol worship will demand that they sacrifice a sheep, sacrifice chickens and this little resources you see they're being taken away, and when they sacrifice a goat for an idol, they just come out with rules, children don't eat it, women don't eat it. So you end up having a few men eating these goats and sheep and the rest of the children almost starving or malnourished". (David Mensah)

There were also issues of food allocation by position within the family, with women letting husband and children eat first, and maybe going starving herself, as were reported by our key informants. If there were several wives of one husband, the first wife had priorities over the other wives, and the children of the first wife were similarly privileged among the children.

Physical capital

Physical capital refers to installations by man, like piped water, electricity, and sanitation. In this section, we will report findings on the themes of water and sanitation. We will also briefly mention other types of community infrastructure that seemed to be of importance.

“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. Those are the most serious problems I am thinking about”. (KI-3)

In the villages there were no electricity, but NEA worked to provide boreholes for water and latrines for sanitation in all villages. This was work in process. The distance a woman had to carry water obviously made a great impact on her health and wellbeing, it was described as one of her toughest tasks and which demanded a lot of time and effort in a full schedule. Not only the distance to drinking water, but also the quality and amount of water available is important, according to literature. In our data we found reports that water scarcity reduced hygienic standard in households, and also stories of illnesses spread through drinking contaminated water from the rivers. Interestingly, we were also told that not a few people preferred to drink water from the rivers rather than from the new wells due to taste preferences.

NEA is also working to put in place various infrastructure that might better conditions in the area. In addition to boreholes and latrines, schools are being built and there is a hope to build a health clinic. Having a market in the town was also reported to be an asset. If you lived far from the market town, you had to consider how to spend your few cedis – on transport or to buy food at the market?



Market along the main road to Accra

Natural Capital

Natural capital refers to the resources provided by nature. This section will be fairly brief, as this is a shared resource that does not stratify between women within the area. Across regions with different natural and climate conditions it might be of great importance. Within a small area the social determinant of health related to natural capital seems to be the preparedness to cope with trends, seasonality and shocks presented by nature. In the Bole district, the general threat to the population is from droughts, which ruins harvests in bad years. Women from the villages reported how they had been hit by dry seasons and therefore had not been successful in the groundnut programme. This is a highly realistic threat. The capacity to cope during such natural disasters is vital in this region. Coping capacity is increased by diversification, both of income and of nutritional basis. NEA is working to inspire to more diverse nutrition, introducing a highly successful aquaculture project in the regions. Also, women are given money to buy a goat when they complete the groundnut programme after three years. This goat serves like a 'savings account' to carry a family through in seasons of drought.

Also the protection of the environment sorts under natural capital. This theme is presented in the section 'political capital' to illustrate how different forces in the community work together to achieve more health promoting conditions and procure a sustainable basis of natural resources in the long run.

Human Capital

“Human capital represents the skills, knowledge, ability to labour and good health that together enable people to pursue different livelihood strategies and achieve their livelihood objectives. At a household level human capital is a factor of the amount and quality of labour available; this varies according to household size, skill levels, leadership potential, health status, etc.” (DfID Sustainable Livelihood Framework)¹²

In this section, results from the following themes will be reported: *Work load and work-rest balance, illness and health, motherhood and fertility, formal education, informal education, health education, happiness and wellbeing.*

Work load and work-rest balance



The women told us stories of very hard lives. A typical day in their lives would look like this: They would get up early in the morning, take care of personal hygiene, and next fetch water and firewood (see picture to the left, with large mounds of firewood in the background). They would prepare a meal for the family, get the children ready, sweep the compound, and clean the dishes. Next they would walk to the farm, their youngest children accompanying them. They would spend the day in the scorching sun, tending to their groundnut plots, working without other tools than short hoes. Doing this work, it would not be uncommon for them to carry one baby on the back and another in the womb. After the day's work on the farmland was done, they would return home to start a new round of meal preparation. Next came fetching and preparing bath water for children and husbands, followed by putting the children to bed. Nights would be interrupted by breast feeding and attention to sick children.

“Some of these women I don’t think have ever had any seven hours sleep, they’ve never known that in all their life, the child is crying, feeding this one, this one is sick, so sleep is intermittent, a couple of hours, she’s up. One hour, she’s up. And then the day finally breaks, and then it’s worse, go for water, go for this, go for that.” (David Mensah)

¹² For DfID ‘Sustainable Livelihoods Guidance Sheets’ see www.eldis.org/vfile/upload/1/document/0901/section2.pdf

This rhythm of work and toil was confirmed from key informants as well as in group interviews and seemed to take a hard toll on women's health. The following are notes from one conversation with women:

Loss of appetite as a result of tiredness. Difficult to take a bath. They have to clear the land, help husbands work, peel cassava, carry firewood back home sometimes with babies at the back. At times some of the husbands have different farms.

It was agreed that both men and women work hard, but that women get less rest than men. Both men and women farm or do other income-generating work, but after the work day is over, it is traditionally the woman who does the food preparation, hauls water and firewood, and prepares baths for the children and also for the husbands. It is also the woman who must take the stress of interrupted sleep due to children. So both women and men work hard, but the women get less rest. This is confirmed in both group and key informant interviews.

"We go and work equally with the men at the farm. When we return home, the men sit or lie down. So we work more than men". (Woman)

"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)

Thus work-rest balance might be of importance as a social determinant of health for women. Work has a paradoxical role for the health of women: a lazy woman is not respected, but too much work is detrimental to health. Work is important to procure resources, and even if a woman feels completely worn out, she is happy if she is well enough in the morning to continue working: without work, no food.

Illness and death

The women were asked what was their greatest problem, the hard work load or the illnesses. There was full agreement that illness was their major threat.

"Good health is our greatest need. If you are healthy, you can work. Whatever I can get to make me healthy is my heart's desire." (Woman)

The women were asked whether they knew any women who were really healthy. They responded that every woman had some kind of ailment, serious or less serious. Among common complaints were musculoskeletal complaints (pains in waist, joint, back, legs), and headaches.

"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)

"I don't see any of them being healthy. They are only trying, they are not healthy. They are only trying" (KI-3)

Hernias were contracted through hard physical work, and ruptured hernias caused the death of many women. Even when surgery was provided by medical teams, the women had to return to hard physical work so soon that the hernias reoccurred. Other dominant health problems in the region were communicable diseases like malaria and STDs. Unknown STDs caused problems with barrenness, which could really influence the wellbeing and status of women. Most of the women had given birth to many children, and also experienced losing one or more children. Average number of children in the four groups was 7.35%, with a range from 1 – 13 (in Ghana, total fertility rate in urban areas was 3.1, and in rural areas 5.6, according to the 2003 DHS final report). The average number of children lost in death in the four groups was 25.73%, varying from 18.6% till 34.3% over the different groups¹³. The widow who had given birth to 13 children had lost 8 of them. The death of a child was described as something felt very deeply:

"It is very painful like pepper in the eyes". (Woman)

"Child death is painful. There is no single day that you will not remember it. All my children who passed away were grown up, whom I used to converse nicely with. Even if he was small it is painful. Any day you count your children their number is always short by one. Anytime you are lying in bed it is like the child is still lying in front of you." (Woman)

¹³ Obviously this number is high. We cannot give any statistics for comparison to the average level in Ghana, as we do not have information on at which age the children had died. Such age information is the basis for statistics on child mortality.

There was an obvious feeling of helplessness when it came to preventing the death of a child. Some women felt their children had got medical care too late because they had not had the money to seek health care. One woman asked to be taught how to prevent their children from dying. Yet another woman felt nothing more could be done:

“When death comes, there is no remedy. You may have taken the child to a hospital several times but he died. It is God that gives and it is Him that takes.” (Woman).

This was also supported by information from the key informants:

“One of the things that are very evident too is that there’s an acceptance of good and bad happening in your life. (...) I know that there have been times when there has been medical malpractice, and someone has died, and I just am so angry at this loss, (...) And yet, somehow, somehow people here are able to not blame those people, even if that needs to happen for things to be better, but they are able to say, just ‘Well, that’s life’”. (Brenda Mensah)

Thus there is a paradox in the general acceptance of status quo – it might promote mental wellbeing and coping with hardship, but at the same time it might prevent the action necessary to promote conditions conducive to health and survival.

The long distance to health clinics and lack of proper hospitals caused problems in the area, and was believed to increase child and maternal mortality:

“Yes, child mortality is also a big problem. The mortality rate is quite high. I wouldn’t be able to give a percentage, but, it’s unacceptable. Some of them, I think it’s due to the fact that from conception up till delivery they never attend antenatal care. They are just at home until they are ready to deliver. And 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 kilometers...”. (KI-2)

Motherhood and fertility

Family planning methods were not yet firmly established in the area, so to a great degree pregnancy followed pregnancy until menopause, separated only by a period of breastfeeding of about seven to

eight months. The onset of a new pregnancy also restricted the duration of breastfeeding of the previous child.

Many women expressed having more children than they would prefer to have:

“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)

“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)

The NEA directors also felt high fertility to be a main health threat to health and wellbeing in the villages, pointing to the role of the men:

“ (...) and also with family planning that we are encouraging the men, whenever I get the chance with the men, that is one of the things you could see it almost, telling them to, cause that is one of the ways of strengthening their homes and their wives, is to agree and cut down the number of children. (...) So these women, our women here, they don't have enough hours to sleep. So if we can cut our family sizes, that, then the women be, will get rest, for these are some of the things...” (David Mensah)

“ (...) There is a woman who has only one child(...) She's so strong, but she does farming, you know, so I think one of the factors is be able to plan their children, like giving birth, future, and it will also help them maintain their health.” (KI-1)

One of the women in the group interviews explained reasons for having many children:

“When I began delivering children, I had two boys. I needed a girl and thought the next child will be a girl, so let me try bringing forth again. The next child was still a boy, and again and again. This is the reason some of us bring forth many children”. (Woman)

This quote points to an interesting fact: even if the culture is predominantly patriarchal, the girl child is valued and sought for. She might be a resource for the mother as she would take part in other types of activities than what a boy might do.



Children at play in a local village

There also seemed to be strong hope connected to children, hope that they would succeed and that they would be able to support the family in the future. For some women this was an incitement to have more children. As one woman expressed it, it might be the very last one, the one you had not yet given birth to, who would turn out to be the 'good one'.

It was obvious from both the group interviews and the key informant interviews that the children had an emotional role as well as an economic role in the family. Previously boys were preferred because of their higher economic potential, but with education of girls that had changed.

Formal education

The situation around education was complex. There has been a change of attitude, with education especially for girls being appreciated far more now than previously. For most of the women we interviewed education of their children was the first thing they spent money on. One of our key informants had been the first (and only) girl from her village to receive a University education. She

had the following story to tell: her mother had had four years of schooling and qualified to go to nursing training. But her father having cattle to take care of refused her, saying “How can I send a lady to school, she will just go and waste my money, she won’t do anything”. Later on this woman (the mother of our key informant), who had very little education, became a respected woman in her village through other capacities than formal education:

“She doesn’t mingle herself with anybody, always that kind of reserved type, hard-working, so it is like so many people are looking up to her. So if someone is going to farm, the person comes to her for advice, you know. There are so many things. She was the first woman to build a house in the village. You know, you know, so she is like someone almost everyone is looking up to in the village, she is so much respected. She just does not like making friends. And when you come to her, she has time for you”. (KI-1)

Our informant was sent to primary school, and was very gifted. But she did not like school and would follow her mother to her farm as often as she could, her mother doing nothing to stop her. Still the little girl would pass all exams. Her aunt was a teacher and insisted on her going to school, organising for her to go to a boarding school. Though it was hard, this distance from the village and her mother helped our informant complete her basic education. Later she continued schooling more locally, and was selected to receive community support for further education through competition based on achievements. Still, to go to University she needed to raise money herself, in this very poor environment. Now with a very strong motivation she worked hard, cultivated her own garden to raise money, asked for support where it was possible, and finally managed to finance her University fees with the support of NEA. This girl today has a University education and is the pride of her village, and of her mother. Still she has a very interesting story to tell when it comes to how an education raises the status of a woman: As long as a man is not educated, and that to a high level, he will not respect a woman because of her education. There seems to be a need to raise the education of both women and men for the situation of women in a community to change. This informant estimated that a man would need education higher than senior high school to respect women.

Another key informant came from another poor village and walked 5 miles and back to school every day through the nine years of his primary and junior high school. He later got a University education, making his father very proud.

“Yeah, he’s happy. He never went to school and he is proud of me. To have come from the site of the village, gone to high school, gone to university, he’s proud. It is not easy to come from that village and even be able to go to high school”. (KI-2)

Today he compares himself to his friends without education, seeing how hard it is for them to manage, to make a living, and how fast their families are growing.

Primary and junior high school has recently become free for all children in Ghana. One key informant told us what happens to girls of 16-18 years: when they have completed junior high school their mothers will tell them to go to the nearest large towns to work (kayayoo) while they wait for the results of their exams.¹⁴ If the girl fails her exams, she will normally go back to work in town in stead of re-sitting the exam. If she qualifies for senior high school, NEA will support her through senior high school.

Informal education

After having taken part in the groundnut programme, several women had been elected to the District Assembly due to the experience gained. Brenda Mensah explained how she had seen group participation give status and increase the confidence of the women, giving them practice at speaking in groups and expressing their opinions and views.

Health education

Health education was held forward as important. It was reported to affect number of children through family planning, it affected quality of parenthood when it came to protecting young girls from untimely pregnancies, it affected health care seeking behaviour, and nutrition practices.

One key informant meant education would be one of the most important factors in improving the status of women in the area, especially health education about family planning:

“It generally comes to this child-bearing. I think they should be educated on family planning, most of them should be taught how to space their children, here most of the time you see the child is just one year and the mother is pregnant again, the child is so small and the mother is pregnant again, so they give birth to so many children and are not able to take care of them too”. (KI-3)

¹⁴ Kayayoos are working in the streets carrying water and other goods. As it happens, many of them fall into prostitution due to the hard circumstances in the towns). “Prostitution... they wouldn’t tell you to do prostitution, but they would tell you go find money, go and work and get money and come”. KI-1

“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. In the evening when you finish eating then you go out and you’re with the boys, ehe, until late in the night. Some even sleep with the boys, and then they come back. They don’t take any good care of that”. (KI-3)

Because of this ignorance about reproduction, and because of the ‘kayayoo’ practice, many young girls start having children around the age of 16-18 years, making it more difficult to find a desirable husband.

In the group interviews one participant expressed that education now made it less important to have boy babies. It is not certain whether this was so because the parents were educated to esteem boys and girls equally, or because girls also received education and were therefore of equal economic importance to the family. Women in the group interviews uniformly expressed a motivation to have fewer children so they could educate them all.

Happiness and wellbeing

Happiness is a major theme in the Social Determinants of Health project, as we try to identify factors that protect the wellbeing and health of women. During this field visit, we asked the women in the group interviews what made them happy and healthy. During the visit we observed that the women were quick to smile and laugh and seemed to have a strong sense of humour despite their harsh living conditions and the work load of their days. This interesting combination was brought up for discussion with key informants. In reporting the findings, I will first share what the women told us about happiness, next I will report from the key informant interviews.

The women were asked what made them happy. Most of them reported very down-to-earth reasons for being happy, reasons related to survival, health and being treated with love and respect. The following are all quotations from group interviews of reasons for being happy, and of what the women reported to be their greatest wish in life:

“When as a result of good health, you work and get good yield from your farm, you become happy”.

"We have prepared our lands for sowing, but it is not raining. If it rains today, we will all be happy".

"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".

"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".

"When you wake up and see all your children up from bed, you are happy because it is not so for all mothers".

"When you are tired or ill and he[the husband] shows signs of care and love and even uses warm water to massage your body in place of medicine [which he does not have money to buy]. In doing this, if he talks gently and lovingly to you, you will be happy. You may in return prepare such a nice meal for him as you have never done".

"Sometimes when you are ill and the man does not have money to take you to hospital, what he will tell you will make you happy".

"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".

"If I am helped to be healthy, I will be more glad than having money".

"Whatever help I can get to be relieved of little ailments is my greatest wish".

"Good health is our greatest need. If you are healthy, you can work. Whatever I can get to make me healthy is my heart's desire".

"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".

"I am happy when my husband gives me money for housekeeping to supplement what I do every day".

"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.'"

When we turned to the key informants, several reasons were given why the women could be happy despite their demanding lives. The foremost reason given was that they were used to local conditions and compared themselves to other people living in the district, not to richer people in the cities¹⁵.

"Maybe one of them is that they have always lived in the scope of what they see. They haven't seen much, that this one has this, this one has that, that is the competition, so much".
(Brenda Mensah)

"That is, that is just what I'm trying to say, and that's what I mean just they look just around here, what they see. You've lived in a place where somebody is not having two cars, two bicycles, ten horses and this and that, it's just being, your life is determined by how much food you have, actually, you know. And last week when a woman gave a testimony by saying that this week she has not been sick, her grandchildren has not been sick, these are big things, this is all she sees as being rich, she has not been sick this week and things like that. That's the simplicity of life is what they know, and they judge a lot of things according to that. And if they can have food to eat, they should be grateful, that they have food to eat. (...) So there's a real significant deep appreciation for the gift of life, for the gift of little things. I think that is what makes them so happy". (David Mensah)

"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_3

This brings up a new paradox: Development and exposure to media brings a new basis for comparison to the remote areas, which might decrease satisfaction with local conditions, at the same time as development is necessary to reduce mortality and morbidity.

¹⁵ 'All comparison is done locally', as was also emphasized in the Ghana reference group that met in Bergen in August 2008, see Appendix IV

Another reason given was that Ghanaians are generally happy people:

"I think smiling is one of the virtues that a lot of Ghanaians possess. A lot of Ghanaians, even though they are going through hardship, still they smile". (KI-2)

This issue was also brought up by the Reference Group (App. III)

The same key informant went on to introduce another reason for happiness – how personality and upbringing of an individual makes a difference in personal attitude¹⁶:

"But I think the upbringing of the individual is important. If you live with a daddy who is always shouting at you, and when you hear your daddy coming and everybody is running for cover, you cannot smile in that atmosphere. But if you come from a home where you can sit and talk with your daddy and mommy, you know you can smile. So how the individual is brought up can contribute to whether he will in the future smile (...) But happiness too I think is related to the individual. There are some people who have learnt to make themselves happy, despite what they go through". (KI-2)

The quality of the relationship was confirmed by the key informants as one important source of happiness for women in the area and will be further reported on under the section on social capital.

The description of the women's happiness in the preceding text does not mean that all women were happy. There were many stories of grief and loneliness, of endless tiredness. Also, one key informant reported that women who were healthy and happy were not as many as those who were not. There also seemed to be more reports of happiness from the key informants than from the women themselves in the group interviews. This paradox was explained by David Mensah as a phenomenon related to the researchers' being white people with a 'potential bag of gold' to provide resources. Face to face with a white person the villagers have an agenda of procuring resources. As a result misery might be overemphasised. To get really truthful communication and share the really good times with the local people David Mensah at times had to visit people without the company of his Canadian wife Brenda, even if she has lived in the area for close to thirty years:

"As soon as they see an expert, they just raise this topic of 'Oh, everything is bad, this and that,' just hoping that more will come from above. That's one of the bad things people have.

¹⁶ This is interesting seen from the perspective of positive psychology, where variability in subjective wellbeing (or happiness) is thought to be approximately 50% determined by genetic inheritance, and where there is certain range within which a person can regulate his or her happiness.

These people, when we are together alone, they are the most happiest of people, like I have been in Canada and US and other places and I really know what joy is. And they have it. A lot more than in Canada. But you throw an expert among them then they change, they just cry poverty, they cry pain, they cry everything, so quite often I will just, I will just tell Brenda, you know, 'Don't go to that meeting, let me just go there and I will just find out real things.'"
(David Mensah)

Summing up the findings, it seems obvious that there are very tough sides to the life in the villages, but that happiness coexists with hardship. Happiness and dreams are related to the very basic needs.

Social capital

Social capital will be reported in four sections: *community support, personal friendship, marital relationships and changing family patterns.*

Community support

When it came to the level of community support, reports varied. Generally there seemed to be an existing system where one could call in the community to help with particularly work tasks.

"A relation could come from their home village to settle here. He comes with nothing. Barely nothing. You'd be surprised. In a years time he would have rooted and set up his farm. You would be surprised at the amount of work he has done. As soon as he comes, somebody will offer him a place to sleep. Some will make sure he has land to farm. If he no money, they can help him get seed to plant. So that he can stand on his own". (KI-2)

There were villages having communal work days, where for instance every Friday was taken off farming and spent doing other types of work. On such days you could call in people to help you thatch your roof or help with your farm or similar. All you needed to do in exchange was to feed the workers for the day. There were some reports, though, that such systems were crumbling:

"But as I said it is diminishing. In the past it was common to find that such a community, in the farming communities, if someone falls sick, the entire village can mobilize themselves to go and help the person round the farm. It still happens, but not very common these days. In the past, you know women in our groups they will mobilize and go to this farm and do that. But I think that is also diminishing". (KI-2)

When asked why he thought it was diminishing, this key informant answered:

"I don't know if it is the economic situation that is making people think like, you know, trying to get independent. They think, if I'm going to spend my time helping at someone else's farm instead of my own farm then I'm going to lose". (KI-2)

It was reported across all information sources that it was hard to find economic or material support.

"Some friends will listen to your long story and will not help you. When you leave them, they will say, "If I give you my money, what will you do to pay my money back to me?" She will not say it in your presence. For that reason, I won't go to a friend with my need". (Woman)

If you needed food, people would try to stretch scant resources to help you, but if you needed other material goods, things had to be given as loans, and such loans were hard to obtain due to the general resource scarcity. Relatives or even friends were no reliable sources of material support, and widows seemed to report the greatest difficulties. Still it was quite common that when a man died, his relatives took over responsibility for some of the children. This was considered a relief for the woman in economic terms, but came at an emotional cost as families were split in a vulnerable situation. This emotional price was reported from both mothers and children who had experienced it.

Personal friendships

Personal friendships and social participation existed to varying degrees.

"I think that in the villages that friendship still exists. And that is a good thing that is happening. In the village, anything can happen. So if you choose to live alone like an island, if anything should happen, you know, there is nobody to support you. So, friendships still exists." (KI-2)



Women had little time to set apart to enjoy with friends. They mostly shared friendship and social times while working together with other women. They were reported to adjoining farmland plots so they could keep each other's company, to fetch water together, and even to make drumming songs out of pounding 'fufu' for meals (see picture to the left). At special celebrations work was set aside and

women gathered to share times together, like around Christmas where in a certain village women put aside work for one week of singing and dancing in the streets. Men had more time to spend sitting chatting with other men, sometimes at the cost of time spent with their families.

"They prefer to go and sit and chat with friends and only come when food is ready rather than sitting there with your wife and children to talk and to interact and to be with them, crack jokes and things like that. That is what a lot of women will have to do. And I think if they could learn to do that, their wives and children and whole family would be happier. (...) You know, just having a good time relieves a lot of stress, having a good time". (KI-2)

Actually a special remark were given about drunkards, who shared very good times together, sitting and drinking ignoring their work. So, hard work was a factor seemingly limiting friendships. Women in the group interviews also expressed loneliness, stating that death made them lonely. Sometimes when they went to another person for comfort they ended up feeling worse, as that person were even lonelier. It was even reported that crying too much from so many deaths caused eye problems.

There were also reported that different villages had differing levels of social interaction, with people some places tending to spend more time together.

Marital relationships

In the Bole district, as in Ghana at large, there has traditionally been a system of patriarchy.

“So women are not really listened to in the communities. They know they [men] are the head, whatever they say it’s final, and a woman knows it. It has become like accepted. When the men are even talking like even in the house, if a man should come to my dad when they are talking, my mom dares not say a word even if she can say something, (...) because she is a woman”. (KI-1)

There have been male lines of inheritance. If a man died, his farm went to his relatives, not to his widow. Therefore, providing women, and particularly widows, with their own farm land, strengthens their position and economic security. Men are the ones with the final say when it comes to family size and family planning and are a target for education in this area. Men have the first right to food when it is scarce, and a woman might go hungry to feed her husband and her children.

“So usually when the food is not enough, what the parents do, or the mother will do is share it to the husband and then the children, and she starves”. (KI-1)

It is also obvious that a husband can be considered a good husband or a not so good husband. A man of good character was reported not to chase women, not to be a rapist, a drunkard or lazy. Several women described the friendship they enjoyed with their husband, and the way he helped her with her hard work. One woman would never have anybody but her husband to assist her during childbirth. The worst husbands seem to be the unfaithful ones, causing their wives a lot of agony.

“Chasing other women, he could even bring a woman and tell my mom to leave the room, so he’s brought a girlfriend, aha. So it has always made her to think, and she has even developed headache as a result of that, you know, so I ... the way a husband, depending on the pressure the husband puts on you, can really make you sick, and has make some people really sick. Some have gone mental, you know, some severe headache, my mother had severe headache”. (KI-1)

The respect between husband and wife, the atmosphere in the home, and the understanding of a husband of his wives health risk are emphasised as important health factors in the key informant interviews. NEA is working systematically to change attitudes in this field. At special relationship training sessions arranged over several days at the NEA base, men have been asked to provide bathing water for their wives during the stay, instead of the other way around. They have also been told to serve (not prepare) food and drink to their wives before sitting down to eat themselves. This has initially been understood by the men as a good joke, but after going through three days of doing

these exercises the men reported being amazed by the way such activities renewed their relationships with their wives:

‘Just like a brand new woman’ and then the men would give you all the stories about how their women were changed, NN he came to the meeting and said, ‘You know I just found something today, how terrible we husbands have been. The first thing I met my wife this morning, the first thing she said was ‘NN thank you very much—’ (David Mensah)

Such changes are slowly but gradually spreading in the villages, and very much so because of role models.

“If you want your wife to live long, you have to help her (...). And these are the things, you know, people who are blind to the fact of your worth as a woman, by making a donkey out of her, you know, it is some sort of just blindness”. (David Mensah)

“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)

When asked about friendship and communication between man and wife, one of our key respondents answered:

“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 (...) So I think if the husbands learn to stay home to, you know, talk with their families, to communicate better, it would make their wives much happier”. (KI-2)

There were some report of husbands getting jealous because of the money their wives earned, but mostly the women emphasized how contributing financially improved their status in the family, and also the quality of their relationship with their husbands:

“When you do not contribute financially towards the up- keep of the house, sometimes your own children do not give you full respect. If you earn money and are able to help with some of their needs, the children respect you as a mother”. (Woman)

“Before the groundnut program came, every time I looked up to my husband for everything - soap, salt, fish for soup. When he is hard up, he gets angry when I make any requests. Now that I realise 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)

It was clear from both group and key informant interviews that willingness to work was strengthening the status of women. There was no understanding for lazy women who were not willing to make an effort to provide for her family.

Changing family patterns.

Family patterns were reported to be changing from a system of extended families living in compounds, to modern patterns where every new family established a household of its own. In several ways this was explained as deteriorating support. In the traditional system you could not let your aunt go starving – she was there with you. Living in extended families was explained as a challenge as well – you could not keep resources to yourself but had to share.

“I think over the last, you know --- you usually found compound houses, very large houses. The father lives there, and the children who are much older live there with the father in the same home, but now everybody is moving to their own house, so I think, on a whole, it is affecting how people live in their homes too (...) In the community level everybody is trying to be independent, care only for himself or herself and their family. I think that is what is happening. Everybody is trying to be independent”. (KI-3)

The strongest factor influencing the change of family patterns was exposure to media like radio and television. As mentioned previously, development and exposure to new information can have a paradoxical effect, strengthening some social determinants of health and weakening others.

To sum up, there seems to be strong traditions for giving support through the community and within extended families, but social patterns seem to be in a transition where social support might be at risk.

Cultural capital

The importance of religion and culture for the status and wellbeing of women received attention especially in the key informant interviews. In the district, there were three religious groups:

Traditionalist, Moslems, and Christians. These lived peacefully together in the villages, but had different practices related to many areas of life. Of particular importance to the health and status of women seemed to be the traditional faith, or fetishism, because of the large number of taboos. These taboos seemed to be uniformly benefitting men. Only men were allowed to eat for instance chicken and eggs, which were of the most important sources of protein in the area. Also, offering to village idols kept many families in poverty. Fear was so dominant that one would rather sacrifice a goat to the village idol than to feed starving children. Moslem and Christian families seemed to fare better. Changing from Traditional to Christian faith had given many women access to better nutrition, and we heard many stories of people welcoming a transition from the Traditionalist faith. Homes where Traditional faith was practised were also described as less hygienic than other homes. Dr. Mensah grew up in a Traditionalist home and village and knows the conditions of the culture well.

"You can go into a fetish place and you look at the woman in which they are sitting, and you just think it's a canteen for disease. You know, you see heads of sacrificed goats and dogs hanging all over the place, of course for most of the shrines (...) one of the first things is filth, so there is a lot of filth. They don't use toilet rolls and things like that, they are holding this, there is little water, you know, just around the house, everywhere!" (David Mensah)

In the Traditional faith, some women were considered witches. Many old women were at the risk of being accused of sorcery after their husbands died, maybe especially by the husband's relatives. Such women were at the risk of being deported to a remote village where they were left to die. Changing such traditions protects women, and the changes are generally welcomed in the communities. NEA particularly aims to empower women at risk. When spotting an elderly woman at risk of being ostracized from society, one approach was to give her a role within NEA. She would be appointed 'agricultural contact' for that village, so that everybody who wished to benefit from a NEA programme in that village had to consult with this woman. Protests among men were strong in the beginning, but when told that this was the only way they could access resources from NEA, they complied. Also, these women were allowed to ride in the NEA truck, one at a time, next to David Mensah when he made his rounds visiting the villages, giving her a strong symbolic status. Over time the status of these women increased so that they are now esteemed resources in their villages and seats are prepared for them next to the elders at certain village gatherings.

"First, it used, like, if you were known to be a witch or a wizard, there was a way of dealing with such a person. Like chasing you out of your community, and just go anywhere and die and nobody cares about you. But now people are with Christianity, they are beginning to

accept these people, there are no longer such traditions, there used to be such things as female genital mutilation, but with education people have come to understand and to see the side effects of it so that they no longer do it.” (KI-3)

Another practice that has been changed is the funeral celebrations. Funeral celebrations were, and still are, large gatherings with up till thousands of people. Visitors have to take time off from their work, neglecting income opportunities, and they also have to bring gifts. Hosts have to provide food and drink for a multitude of visitors. The joined effect of this is impoverishing. Funerals are still large events, but it has been decided among the villages that each village should host only three such occasions every year. Burials are of course done as deaths occur, but funeral celebrations are combined into fewer events.

“Everybody was just worn out, going to funerals (...) When I raised the issue, everybody said: we’re just so tired, if you can just really talk to these chiefs this would be the biggest change that would help us”. (David Mensah)

Political capital



It seemed clear from our observations that changing such cultures took political capital. Forums were needed for people to discuss desired changes, initiators were needed, bridging of several communities were needed for coordinated change, and the right levels of authority was needed to effectuate the changes. In the case of this field visit, such political capital was provided through the system of chiefs for the different villages, who were united under the paramount chief for the whole tribe which included many villages. The director of NEA was the chief of his local tribe through family heritage, and he was serving as paramount chief for all villages in his tribe (see picture of the

traditional Chief Costume) There were systems of communication and negotiations at different levels. Such political capital seems to be of great importance to improving living conditions in an area. The following are notes from the individual interview with Brenda Mensah, about the work of NEA when it comes to peace building and environmental protection:

Also peace building. Even before chief did a lot. In first project area the chiefs [were] cohesive, knew their position and worked together well. Here autonomous- cared about themselves first, next their community, the area not very much. [David] has been able to draw them together to care for sustainable development. Help for whole area. Taken a lot of time. Bring together for meetings, talk, prevent conflicts, talk about reasons for conflict, solutions. Uses them when there are conflicts, together to solve.

Several other areas had been influenced through successful cooperation between people in the area: Fishing by DDT poisoning in the Black Volta River has been stopped after a combination of successful education and patrolling of the river. This fishing tradition, where fish was killed by the poison and next eaten, had of course had serious health consequences for people in the villages. Also, the cutting down of wood for production of charcoal to sell to the villages was being stopped. This practice seriously hurt the environment and would hurt the local people in the long run. Even land of economic trees like shea was cleared.¹⁷ On a short term basis, however, negative impact was felt through loss of income, as was reported in both group interviews and by key informants. NEA was working to substitute for lost income through income generation through other activities.

A third example of the benefits of good village leadership was given by one of our key informants:

“If 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 those assembly members in those communities, there are some who are really hard-working, and ensure cleanliness. So if you have such a member on the assembly they always make sure that regular communal labour is carried out to clean the community, but if you go to another community where nobody cares, where they just live like that. 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-2)

Political capital of women was increased as they were put in positions of responsibility, such as being appointed ‘agricultural consultant’ for the village by NEA. Some women were also elected to the District Assembly after gaining experience and confidence from work in the women’s co-operatives.

¹⁷ Shea butter production is an important income for poor women in the rural areas of Northern Region. In the Tamale area, women in NEA cooperatives produce all the shea butter used in the production of products for Body Shop through the firm’s community trade initiatives.

Conclusions

As pointed out in the summary points at the beginning of this field report, several factors have been reported during the Ghana field visit that could be important social determinants of health in this local area. One of the most important lessons from the Ghana field visit is the change that is possible to achieve in an area through concerted action by local leaders. Important factors are at an individual level as well as at a community level. In large health surveys these factors are not always measured, and it is our hope that our findings can contribute to the development of appropriate social indicators for the use in poor ruralities.

References

Carney, D., with M. Drinkwater, T. Rusinow, K. Neefjes, S. Wanmali, and N. Singh. (1999). *Livelihoods approaches compared. A Brief Comparison of the Livelihoods Approaches of the Livelihoods Approaches of the UK Department for International Development (DfID), CARE, Oxfam, and the United Nations Development Programme (UNDP)*. Department for International Development (DfID), London.

Huppert, F.A. (2005). Positive mental health in individuals and populations. In F.A. Huppert, N. Baylis & B. Keverne (Eds), *The science of well-being* (pp 307-340). Oxford: Oxford University Press

MEASURE DHS (Demographic and Health Surveys). Information available at <http://www.measuredhs.com/>

Mensah, D. (1998). *Kwabena: An African Boy's Journey of Faith*. Canada: Essence Publishing.

Northern Empowerment Association: Information retrieved on Dec. 10th 2009 from <http://grid-nea.org/>

Sustainable Livelihoods Approach: Information retrieved on Dec 10th 2009 from www.eldis.org/vfile/upload/1/document/0901/section2.pdf

UNDP (2007). Ghana Human Development Report 2007. United Nations Development Programme, Ghana Office. Information retrieved on Dec 10th 2009 from <http://hdr.undp.org/en/reports/nationalreports/africa/ghana/name,3458,en.html>

UNDP Human Development Index statistics. Information retrieved on Dec 10th from United Nations Development Programme. <http://hdr.undp.org/en/statistics/> .

WHO (2009) Country information on Ghana. Information retrieved on Dec 10th 2009 from <http://www.who.int/countries/gha/en/>

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 your 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?

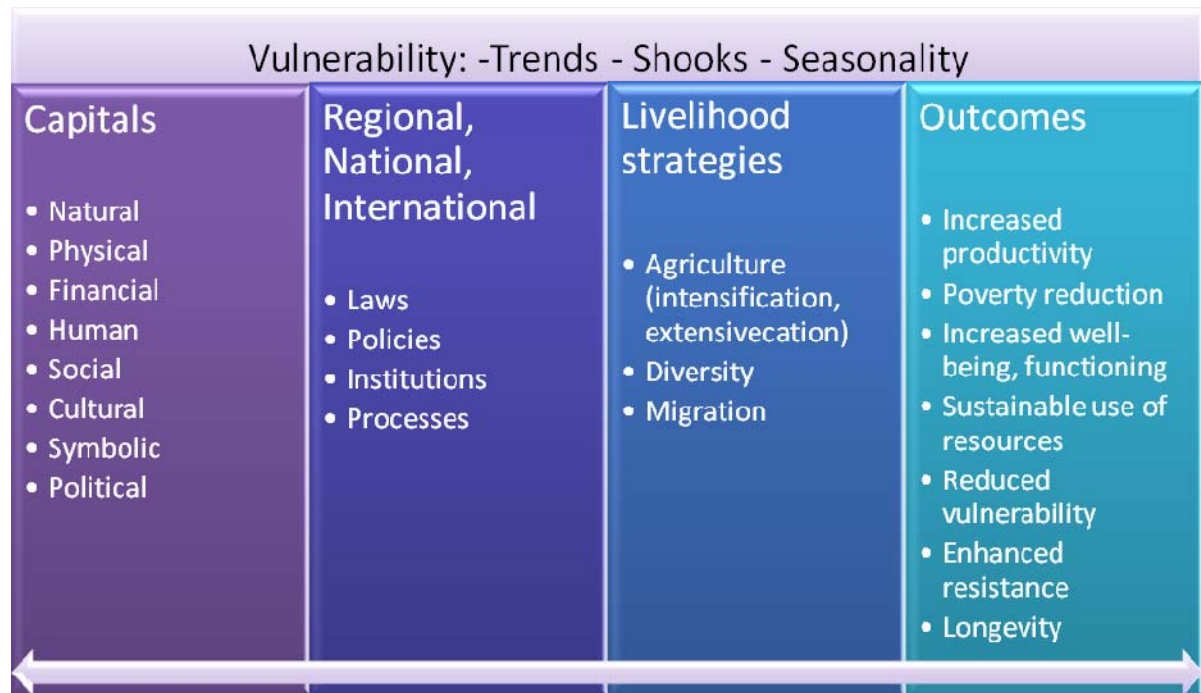
- How would choice of partner influence her happiness and health?
 - Evt if equal upbringing/culture of wife and husband is important
- How does he behave that helps her feel strong and happy?
- How are decisions made in the households?
 - If you make some money, can you decide how to spend it?
- If 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?"

Appendix II.

This is the interview guide we finally used as a basis for the 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?

Appendix IV



Adaptation by MB Mittelmark of the Sustainable Livelihoods Conceptual Framework. See Carney, et al (1999)

Chapter 6. The Haiti Field Visit, May 2009

Norma Perez Gonzáles Brisbois

Overview of activities

The field visit to Haiti lasted three weeks, from the 4th to the 22^d of May. The Reference Group meeting was held 5th May 2009 from 9:00 to 17:15. During the first week, I organized the Haitian Reference group meeting and then I visited three of the poorest urban slum areas in Port-au-Prince in the company of two of the Reference Group participants. I also interviewed two key informants. The second week, I went from Port-au-Prince to Jacmel, in the south-east part of Haiti, where I met groups of active members of different organizations. During my stay, I had the opportunity to meet a group of expatriates and Haitian humanitarian workers from international and local organizations, working on community development issues in different areas of Haiti. They supported me with logistics and contacts to local women groups to conduct focus group interviews.

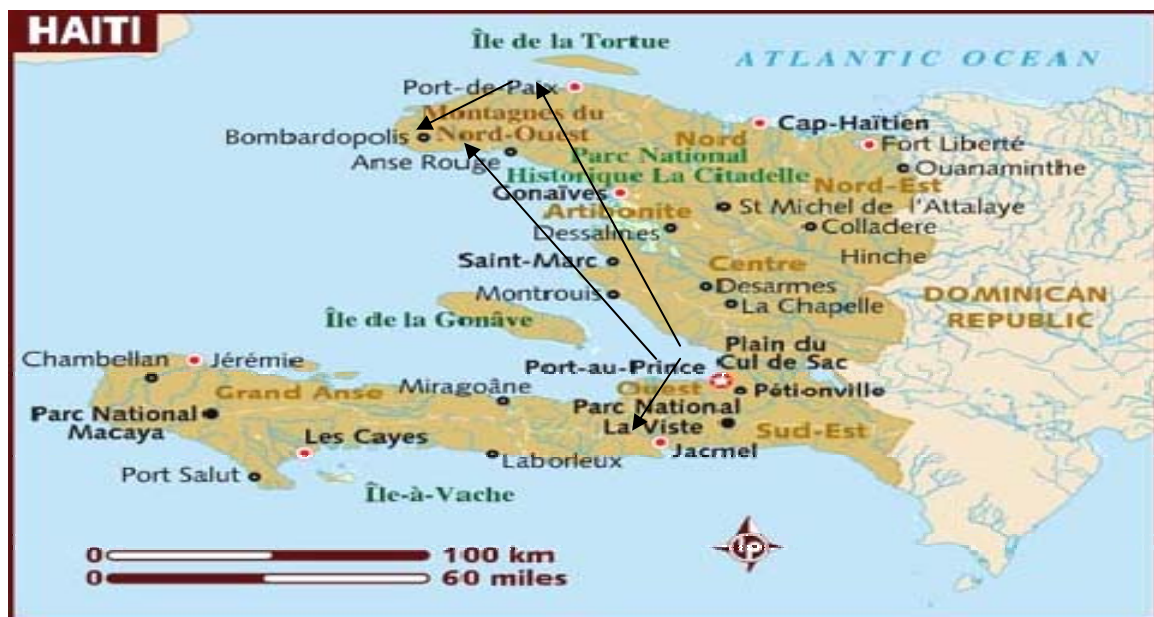


Figure2: Destinations travelled in Haiti during the field visit in May

Summary of observations

- Women's social position within the household affects directly the wellbeing and health of women; a key element is the quality of the relationship with the woman's partner (avoidance of domestic violence, the husband who takes part in household responsibilities and gives social support to his wife, the contraceptive choices, decision making, economic support and his presence in the household).
- Most women in rural areas live with a partner and not in a marriage, what is called in Haiti "plaçage". Being a married woman provides more protection and security than being in "plaçage".
- Promiscuous behaviour by women is an important factor of coping with life stress, as it helps her to acquire material and intangible goods from boyfriends. The sexuality of a woman and her beauty are considered as capitals with which they procure themselves and their family a livelihood.
- Having a lot of children gives a woman enhanced social position in the household and in the community. Having children creates a paradox for women. On the one hand, mothers can make claims for support from fathers, and the children are a guarantee of a woman's future security. On the other hand, there is a heavy childcare burden for the mother, who has very little support and help.
- The burden and challenges of daily living affect women's social position and health. Most of the time women are the ones caring for and feeding the family, doing the household tasks, helping children with homework, working in the field, etc. She has very little time for rest and recreation. The number of children (usually girls) who assist the mother in household is also important for a woman's well-being.
- It seems that mothers have a tendency to neglect themselves in different ways to promote the well-being of their family. Women and girls eat less and worse than husband and boys.
- Women are not well enough supported by laws, and customs and tradition seems to justify the adverse and domineering behaviours and attitude of men against women. The impact of the local culture, tradition and religion is important in this regard.

- Generational transmission of knowledge and tradition, especially orally, is very important in rural areas. The ability to read and to teach others is prized. However women may have high social position even if they cannot read and write.
- Having an informal job, even if it is very poorly paid, is also very valued, as a job gives economic independence from the husband and gives the women a higher degree of freedom and appreciation and recognition in the community.
- The women belonging to and participating in social networks such as churches, women's organizations or community development organizations have large social benefits and sometimes obtain material resources and social support. Such participation is directly and indirectly beneficial for their families and themselves at different levels. In general they are better prepared for life and have better knowledge of their rights and opportunities. The socially active inform and support other women in the community, and receive recognition and respect.
- There is a conflict between traditional health practices and western medicine when dealing with disease. In rural areas, religious affiliation and having knowledge of traditional medicine imparts social status.
- Financial and material capital is often procured by diverse informal livelihood activities. The main possessions are often animals and cultivable lands inherited by the family. These goods give a certain independence and recognition to the family.
- The natural environment is also a very important factor that should be considered, especially in areas where natural disasters are an obstacle to the development and well-being of the community. In Haiti, natural resources are scarce, and this does not help the livelihood of women in poor rural areas. The earthquake in January 2010 is an example of how natural disaster devastates the health and well-being of Haitian women.

Introduction to Haiti

The Republic of Haiti is located in Central America in the Caribbean Sea. It is situated on the Hispaniola Island and shares the island with the Dominican Republic on the west.

It has a tropical climate on the coast and is semi-arid in the mountains. Nearly every year, Haiti is exposed to storms and hurricanes; it also occasionally suffers from floods, earthquakes and droughts. Haiti has endured widespread deforestation due to expansion of agricultural lands and the use of wood as source of energy. A result is soil erosion. Another important resource, water, is far from universally available for the population.

The official languages are Haitian Creole and French. Nine of ten Haitians speak only Creole, which is the everyday language for the entire population. About one of ten also speaks French. Only about one in twenty is fluent in both French and Creole. The population is ethnically composed of 95% direct descendents of slaves, and 5% are Mestizos and Whites. Racism and segregation is common between these groups.

When it comes to religion, more than 80% of the population is Catholic; the rest belongs mostly to the various Protestant churches. But most Haitians also practice voodoo, an African heritage from the slavery era.

Haiti emerged as the world's first independent black republic and the first country to achieve independence in Latin America. This happened in 1804, under the leadership of Toussaint Louverture. In 2004, Haiti celebrated its bicentenary. However, after independence Haiti has endured two centuries of dictatorship and political instability and violence. After thirty years of dictatorship, Jean-Bertrand Aristide was elected president in 2001 with strong support from the military. He remained in this position until 2004. In 2006, a designated leadership took over from an interim government (2004-2006) and the UN stabilisation force has been deployed until the present. Today, Haiti is a semi-presidential republic with [René Preval](#) as president since 2006.

The past period of political instability, natural disasters and extreme dependence on humanitarian aid from abroad, can be some of the main reasons why Haiti is considered today to be the poorest country in the Americas and one of the poorest in the world. In the following some important facts on socio-economic and health conditions in Haiti are presented (PAHO, p.413-421, 2007).

- High inequality in many areas, such as education, income, health and wealth. A very small portion of people is extremely wealthy (4 % of the population has 66 % of the nation's wealth, whilst 10 % of the population has close to nothing). 60% of the population lacks access to health services.

- 55 % of the population is living below the absolute poverty line of U.S. \$1 per person per day, and 71% - more than six million people -lived below U.S. \$2 per person per day in 2001.
- Poverty is even worse in the country's rural areas representing 82% of the population. The majority of Haitians live in remote rural areas without access to electricity, sanitary facilities or even clean water.
- The Human Development Index (HDI) for Haiti is the lowest in the Americas. In 2008, the HDI¹⁸ for Haiti was 0.521, which gives the country a rank of 148th out of 179 countries.
- Only 40 % of the population has access to basic health services in certain departments, and 80 % of people consult traditional health services. Infant mortality¹⁹ is very high: 84 for every 1000. Illiteracy in the adult population was estimated to be 44% in 2008²⁰. 65% of Haitian children will never complete elementary school, and 80% won't ever attend high school.
- 66% of Haitians are agriculturists²¹, yet the UN Food and Agricultural Organization estimates that Haiti produces only about 40% of the food it needs.
- More than 43 % of women are illiterate in the country, but in rural areas the figure is even higher with 80 % of people being illiterate.
- Since 1990, tourism has no longer been a source of income. The image given of Haiti in the global media of being a dangerous place has pulled off investors, donors and tourists from the country.
- Underemployment, unemployment, and a shortage of skilled workers (fled abroad) are three fundamental problems of the Haitian economy. The unemployment rate in the formal sector is between 70-80 percent²² and more than two-thirds of the work force does not have regular jobs.

¹⁸UNDP: http://hdrstats.undp.org/2008/countries/country_fact_sheets/cty_fs_HTI.html

¹⁹Idem

²⁰ http://www.usaid.gov/ht/docs/haiti_country_profile_2009.pdf

²¹ <http://www.nationsencyclopedia.com/Americas/Haiti-AGRICULTURE.html>

²² http://www.usaid.gov/locations/latin_america_caribbean/country/haiti/Haiti_Country_Profile.pdf

- Domestic violence and gender inequality were two of the most important living conditions affecting women's social position in the household and the community. The way men treat women is an important determinant of the physical and mental health of women, and particularly women living in poverty.

Most of the UN Agencies, many International Organizations, and NGOs from all around the world are working in the country, mainly to assist and support the Haitian population in many ways, but especially when natural disaster occurs.

When local people see the number of organizations (more than 500²⁴ all around the country) investing money and time for so long in Haiti, they question whether these organisations are making real changes or whether they are just entertaining the poverty circle.

The shortage of provisions, clean water, essential health care and the unsanitary living conditions bring epidemic diarrhoea, respiratory infections, malaria, tuberculosis and HIV/AIDS. Haiti has the highest infant, under-five, and maternal mortality rates in the western hemisphere (PAHO, P. 418-421, 2007).

Methods

To get the most out of the field visit in Haiti, I took advantage of different methods to collect information at different levels: Reference Group meeting, key informant interviews (NGOs workers and researchers in different study's area), and women focus groups.

The Reference Group meeting was arranged May 5th in a hotel meeting room in Port-au-Prince, the capital of Haiti. It was composed by 14 members from multidisciplinary backgrounds, working and doing research in subjects that concerned the project. The Reference Group meeting commenced with an overview of the project, its goals, and the aims for of the visit. The meeting was recorded and also one person was assigned to take notes during the meeting (see Appendix V). The meeting was held in French at the preference of the Reference Group members.

²⁴ <http://www.reliefweb.int/rw/rwb.nsf/db900sid/CJCN-7JDJEH?Open> Document&RSS20&RSS20=FS

Key informant interviews were conducted in Port-au-Prince and Jacmel. All informants held posts within institutions in Haiti (see key informants name list in appendix III). Most of them had been working for many years on topics such as rural development, community health, gender issues, natural disaster management, and reproductive and sexual health among others issues. The key informant interviews were semi-guided by an interview guide (see questions attached in appendix I and VI), some of them were recorded and field notes were taken and used to document the content of the interviews. Each informant was given information about the project and its goals.

The heart of the discussions was focused on women's social position within the household and the community. The degree of focus on the following topics varied from discussion to discussion:

- (1) The situation of women and gender equality in the rural areas and in the whole country.
- (2) The importance of children and husband as main instruments of motivation and wellbeing but also as adverse factors affecting women's health.
- (3) The impact of the cultural heritage and mysticism on women's living conditions in rural areas.
- (4) Health conditions and access to health cares in rural areas.

Three women's focus group discussions were conducted in different regions in the north west of Haiti; they lasted between 1-2 hours each. Two of the three discussions were recorded and field notes were taken at the time of events. The focus groups were guided by a series of questions (see appendix VI) and two-way discussions, with me posing questions to the members of the group, and with them posing questions to me, and discussions between group members. All three groups were mainly in French, and some of focus group members spoke in Creole as well. I had a translator/interpreter with me.

The focus groups in Village I, II and III were composed by women belonging to different women's organizations in remote rural areas. Today, there is a large number of women's organizations, even if it is a quite new phenomenon in Haiti, especially in remote rural areas.

Reference group meeting

The Reference Group discussion was directed by an agreed upon agenda (see appendix II). The meeting's Chair, Louise-Marie Boulos, opened the meeting by giving a warm welcome and a thank you to the participants on behalf of the project. He then talked briefly about the main challenges in Haiti at all levels, but especially about health issues. I followed with a brief presentation about the

background and aims for the Social Determinants of Health (SDH) project. Afterwards, I gave the floor to each of the participants to introduce themselves and ask questions.

The meeting was held for one day only, so we went straight into the central questions on SDH. Some of the participants thought that the SDH were difficult to identify and measure. It was found even more challenging to classify SDH at a universal level, especially taking into account that people are inevitably attached to their own local cultural context.

There is almost no research on the SDH done in Haiti; it is a quite new perspective and concept even if researchers are familiar with the topic in a more general way. The main goal of the people in the Haiti Reference Group was to conduct local, highly contextual analyses and actions that respond to the needs, capabilities, and realities of people where they live.

The Reference Group emphasised the multidimensionality and connectedness between social determinants of health, mainly those that can be related to the individual level– financial, material, social, cultural, and political – but also the more contextual determinants that also may affect health and social status of women.

Key Informants Interviews

Fourteen key informant interviews were arranged with members from different groups such as local NGOs²⁵ workers, a sociologist, a men's organization fighting against domestic violence, and members of women's organizations from Port-au-Prince, Jacmel, and Anse Rouge.

Discussions with Focus Groups

The three focus groups were mainly composed of women from disadvantaged socio-economic backgrounds, with little education, with a husband/cohabitant, and most of them were mothers of several children.



The first focus group discussion was held in a village called Jean Rabel, in cooperation with a local organization called "Initiative Development" and it was composed of nine women. This group was very animated and motivated to talk about their personal

problems. Some of these women didn't know enough about their rights and possibilities in Haiti. They were resigned about their situation but were willing to make changes. This group didn't have any organized or productive activities, but they were working to get some micro credit for training and other opportunities.



The second focus group discussion took place at Bombardopolis, in collaboration with a local NGO called ADEMA (Ansanm pou yon DEmen Miyo an Ayiti) and it was composed of 13 women. This group of women was quite well organised compared to the other two groups. They knew a lot about their rights and possibilities and were very active in their community, mainly with the support of the local organization that supports women's

initiatives. They have a confection atelier where they can learn how to use a sewing machine and sell the clothes they create to continue to reinforce the association and empower other women in the region.



The third focus group discussion was held at Source Chaude (Anse Rouge) and was organized in cooperation with Ananda Marga Universal Relief Team (AMURT) and in partnership with the local women's association (NPP/AEPA), a grassroots project established in the region in more than 60 villages, composed by 34 women groups with more than 500 women. Seven women were present at the group discussion. Since 2008, AEPA/AMURT

has been mobilizing women in North-Western Haiti to take control over their economic situation by training them in small business enterprises.

Results



As in many other developing countries, in Haiti women have many roles in the household and in the community. Tradition has placed men as the ones commanding and making decisions, while the wives are subordinate to them. In general, the father, (if there is one) is seen as the economic provider (if he has a job) and he brings home farming products for the family.

Generally, the women are the first getting up and the last going to bed. Most women living in rural areas begin work very early in the morning. Typically, a woman wakes up at 4-5 o'clock in the morning and begins the day preparing the food for the husband and children before they go to school. Around six am she leaves home to go to trade at the market. She spends all day in the markets and sometimes won't come back before 18-19 o'clock at night. Then she comes back home and cooks dinner for the family. She then has to do a lot of household tasks (cleaning, laundry, preparing the clothes for the husband, etc).

Reference group members, key informants and women's focus groups all emphasised the heavy burden that women have in their everyday life. The following points were identified

The gender inequality begins from girls' childhood. If the family is very poor and cannot afford to pay for the education for all the children, they will prioritize the education of the boys. The girls have a lot of responsibilities from their childhood. They start working from a very young age with household tasks, taking care of their younger brothers and sisters, and trading in the market.

During the marriage/love age, women have to have children and take care of them and their education. Although the mother is not able to read, she is the one who has to support the children with their homework.

The husband is considered as the "boss" of the woman, she has to do everything to please him and take care of him in any possible way. This includes giving him sexual satisfaction even when she doesn't want to because she is tired. If she denies sex, she can get beaten up or the man will have a reason to look for other women.

In some families, the women are the ones managing the finances. The husband (if he is working) sometimes gives her part of the money he has earned to provide food and other things needed for the family. When the husband doesn't work, it is the woman's responsibility, even if she has no job, to find a way to provide food for her family, including her husband.

Haitian women are considered to be very altruistic. They are the ones expected to provide health care to the family and other members of the community, even if the woman is not a nurse or has no knowledge of health care. They are the ones taking the child or the husband to the hospital and they buy medical prescriptions.

Besides doing everything in the household, some women have to show their ability to work in the field, especially during the harvest period. They are also expected to sell the produce at the market.

The routine burdens affect women's health physically and psychologically. Many women don't know others ways of living since they have been working in their families since they were children. Even if leisure is seen to be a normal thing in Western society, for these women "a moment of rest or leisure" seems to be a luxury. Some of the participants in the focus groups said that Haitian women considered themselves as tireless. They never questioned themselves because it is normal to be tired. For many women in Haiti, this is the typical day of work and they don't really know what leisure is.

Children as mother's paradox: sacrifices and motivating force

Having children is a decisive factor to gain recognition and social position, particularly for women from the rural areas, but it can be a complicated mission as they have to deliver at least four to ten children under very precarious conditions. In addition, many women endure many unwanted pregnancies, as contraception methods are not much used in the rural areas. The number of pregnancies can also be considered a factor of deterioration of the health and the standard of living of the mother. One of the Reference Group members affirmed that some of them are completely "overwhelmed" by all the children and sometimes they feel tired of that situation and, as consequence, it's the unwanted children that pay for it (yelling at them or beating them up).

The Reference Group emphasized that the women who take action against injustices in the community are mainly women with children, and they act generally on behalf of their children. The more children they have, the more power and rights they have to take initiatives in their community. The child is used as a weapon of claim:

"All claims are around their children, if there is something happening in the street, for example, the evacuation of people in the street market, most of the time these women who have children are the ones who speak, and they say: "What will I do with my children, I have 4, 5, 8, 10". For me, the women with children, the child is something that I can not define, but these children are used as a weapon of claim and the number of children determines the weight of the claim."

Poor rural mothers have a tendency to neglect themselves on behalf of securing the education of their children. Even when a woman knows that she is sick, she will not take care of her health, as another participant of the Reference Group explained:

"I meet a lot of women who carry cancer or other diseases and instead of making a trip to town, pay the doctor or find treatments, they will prefer to give priority to the education of her children who are most of the time fatherless."

The women are the ones having access and control of the distribution and trade of food in the markets, but they are not benefiting nutritionally themselves since they eat just enough to "survive". In general, the father and the big brother are the ones having the best part of the prepared meal, while the mother and the other children eat the remainders. Many mothers often may reduce the quantity and quality of the food they eat with the purpose of managing to feed and educate their children, as detailed another member of the Reference Group:

"If she wants to put the children at school, or if she has to face an unforeseen event such as illness, she is going to reduce the food consumption. (...) So, we actually agree that if she doesn't feed herself well, she is more vulnerable to certain pathologies, she is weaker, and her health will be easily affected."

The older children (generally girls) often support the mother in taking care of the younger brothers and sisters and assisting her with the domestic tasks. They also contribute significantly to their communities through work in the house, fields, and many even provide some income to the family at a young age:

"Sometimes the mothers distribute the authority to the older children to help monitor and control the younger ones, even when she is absent, her symbolic authority remains. This deal creates a hierarchical authority and seconds-in-command in the family allow bettering organization and delegation of tasks."

Reference Group members, key informants and the focus groups agreed that for most Haitian women and families with limited possessions, the only hope is "*Timoun is lavni*" (The child is the future). Many of them make quite rational choices based on their goals for their children to achieve a certain level of education. This saying describes in simple words that the children today will be responsible for the well-being of their mother, families, communities, societies and the tomorrow of the world. They are very proud to be able to provide them with a certain level of education. This is

one of the biggest motivations for the mother, to know that tomorrow they will take care of her as she is doing with them today. The mother lives her dreams through her children.

Children are the main motivating force for Haitian women to get back on their feet, despite all the difficulties and sacrifices the mothers face all along their lives.

“Even when a woman is poor she lives in dignity because she is appreciated in her community and there is solidarity... At the same time there is also the idea, “to look ahead into the future”. That’s why when they talk about investing in her children, it is imagining that in a few years, poverty will be wiped out, so there will be an exit somewhere to keep them alive. As we say “hope gives life”,(...), they endure poverty with courage, with dignity as well.”

Men and women

Another important factor determining the importance of the social position of the wife in the household is the nature and the quality of the relationship with her man. Haitians usually refer to any woman who lives with a man, keeps house for him and bears his children as a “wife.” These unions are distinguished from other sexual affairs that carry less responsibility and are less stable than ‘le plaçage’:

“Marriage in Haiti is a concept which dates from yesterday and it is not a very old in our culture. I know men in rural areas. The man has a wife and lovers, and they live like that. The hamper of the marriage came today from Western religions and the Law, which confirm it afterwards”

For most Haitians, a civil or religious marriage is a luxury; mainly the urban higher class can afford it. Only 45% of the population gets married, and even though marriage seems to be an important social marker and a source of protection for some women in the urban areas, it doesn’t seem to make a really convincing distinction in the hard living conditions of women in poor ruralities. Still, one of the key informants pointed out that women living under “*plaçage*” (cohabitation) can be much more humiliated and exploited than those that are married. One of the main reasons is that there is no legal agreement that can protect the woman’s possessions and protect her from violence.

The role of single women is different from the role of married or cohabitating women. They undertake roles as leaders, these are women with a good cultural heritage, education and training, and they often commit themselves to defend women’s causes.

Having sexual partners is a way for a woman to improve her living conditions. The Haitian custom doesn’t accept this unofficial polygamy for women, but some of them can use their “beauty” as an asset to get an important position in the community and material resources.

In Haiti, married men are habitually more economically stable than men in “*plaçage*” relationships, and so it is easier for them (financially) to split from their wives or to begin extramarital relationships. If a woman lives in “*plaçage*”, it is quite normal for her man to have one to several additional sexual partners. Most Haitians (mainly men) recognize that this behaviour is part of the traditions and cultural heritage of the country (especially the voodoo religion). Haitian men are free to have an unofficial polygamous relationship. Polygamy among Haitian men is not a sign of virility but of social and economic achievement: Not many men have enough money to keep more than one family.

Focus group participants and key informants claimed that Haitian wives/cohabitants are very tolerant with their husbands. Most of the time the main reasons are concern for their children and economic dependence, but also love, that pushes them to give several chances to the husband to change his ways. A participant from the focus groups said:

“We woman gives them a chance or more - women stay with their husbands. She has a lot of children, and she gives opportunities and he said he will change, but he does not change. The woman remains with the husband, without taking a decision. She still has her husband and she is confused, humiliated, destroy by her husband. Then, she has too many children, and she is too old, so she stays with him.”

Some women have several sexual partners who provide her with different resources for making a living and to support her family. This practice is not considered to be prostitution, but just a way to use her “natural” resources in a favourable way. One of the participants explained that:

We all know the proverbs in Haiti which say that “the female sex is equated with wealth and it has to be mined/harnessed, it is a capital as another”.

In Haiti, every time a woman cohabitates with a man, she has to give him children as a “proof of love” and to prove they are fertile. This is especially true in poor ruralities. Children are considered as the family core contributing to the appreciation of women’s social position in the community as well.

The quality of the relationship and the way the husband treats his wife/cohabitant is central for happiness and self-esteem of Haitian women. Focus group members explained that some women are not allowed to divorce, and anyway divorce is very expensive, so they stay with their husband even if he has other women. A lot of women don’t know about their rights, they are quite isolated. Sometimes the wives cannot speak in public without the consent of their husband and feel very frustrated. One of the participants in a Focus Group declared that:

“The husbands don’t want to discuss, but to have an argument. They say “No, I am the head of the household and what I say that is just it.”

In Haiti and particularly in rural areas, many women are victims of domestic violence. The manifestations of this attitude toward women are reproduced in others sectors of the society. One key informant explained that:

“All women, regardless of class, education and social position may be victims of domestic violence, violence does not discriminate, especially in a macho society such as this one”.

The oral tradition is still very important in ruralities, especially because many people are illiterate, and sayings are typically used to explain a situation or to justify actions and behaviours that are validated in the eyes of the community. There are many sayings in the Haitian’s oral tradition that show negative connotations about women and their role in society, and that perpetrate conflict resolution through violence.

All key informants and focus group members agreed that violence has serious consequences for women's health. An abused woman will have problems and can suffer from psychological, physical, social and economic problems. Most of the time, women are obliged to live with their “abusers” because they don’t have any support or other choices. The husband also perpetuates symbolic violence against his wife; he humiliates his wife in the street or in public. In rural areas women are afraid to complain against their husband to the police. The institutional and cultural contexts do not seem to protect and support women enough. In remote rural areas women do not have anyone to talk to about this subject, which seems to be a taboo even between women. From 2003 women organizations started to promote their rights and to make other women talk about the problem and know their rights. In Haiti, some women agree that it is acceptable for a husband to beat his wife in some cases such as refused sex, neglecting the children, and burning food.

Education, heritage and work

The Reference Group highlighted the importance that having a job and a received education can play in locating a woman’s social position. In rural areas, a less important aspect is formal education received at school; very few women have it. Informal education, including knowledge about the family heritage, imparts higher social position. Basic literacy raises the social position of women in rural areas, but other competences are important as well:

“Most rural women are illiterate but possess a “natural practical intelligence” to manage their lives and their business.”

Women in rural areas do not necessarily need education to be recognized and have a leadership position in their community:

"An education allows people to hold an important role, for example, a woman who is a teacher in a rural school will have an important role in the community. But there are also examples of women that are not able to read or write, but are leaders of the community. The community doesn't do anything without consulting them, and they have to negotiate with [such leaders] before taking a decision."

Literacy and informal education is the more relevant indicator in the rural areas, as opposed to urban areas where formal education is more important.

"Here in Haiti, people will tell you that it is not because you go to school that you are educated. There is also the aspect of socialization that goes through informal education, but also through intergenerational transmission. Besides the formal education, all these aspects will teach/ train women and will empower them to interact with their environment."

Women are distinguished primarily for the reputation, recognition and role of family in the community. A Reference Group Member stated:

"It is not in terms of inheritance of property or goods, but in the legacy of the family... Even the fourth or fifth generation of a recognized woman will benefit from the position that she occupied in the community or the function she had. We can take the example of a midwife in the rural area. She is a skilled woman in the delivering of babies, she is the one delivering most of the children in the region, so this lady, she will be respected and then so, her children's child will also benefit from that inherit and will be respected too."

Socio-economic position in poor a rural area is also indicated by a household's ownership of essential material possessions including cultivable lands, animals, agriculture and others material goods:

"Even if most women look poor in appearance, I would say, we can see as well that there may be some difference, especially in terms of access to wealth, land and resources of the area."

Women acquire a degree of economic independence when they have informal jobs, like small businesses, alongside managing household tasks. Having a job contributes to recognition and good reputation in the community, even if the job is not well paid or not highly valued such as, for example household servant, working in a factory, or trader in the market.

Social interaction and belonging

Women living in rural areas are dependent on the relationships they maintain with other women, the community at large, and institutions. Maintaining good relationships creates a circle of solidarity for them and their family as well:

“They can hope that in the close environment, they can rely on the network that was created. In general, these are people who cannot help economically but they are more confident in the future, when they know they can have someone that is a parent or a friend who will support their child. So, they do not have economical means, but they feel like... I can say, having this feeling of calm compared to this reality. So for me, it is important the relationship that people develop with their environment.”

The feeling of being bonded, being valued and being useful to their community seems to be an important factor for the wellbeing for these women. One important characteristic is to live with/in dignity, even if they are very poor. One of the participants used a saying to explain this:

“Happy misery is better compared to shameful wealth ”.

Mysticism and Religion

The Reference Group considered that the religious factor is a central one for the wellbeing and social position of woman in rural areas. In Haiti many congregations, but mainly the Catholic, the Protestant and the Voodooist, have built churches all around the country, even in the most remote rural areas. Churches support people with material and spiritual support, especially focusing on helping women and children. Each congregation has active roles for women, especially in the organization of social and religious activities. They are also very much involved through churches in visiting and assisting ill people, and this seems to be an important way to gain respect in the community.

Religion, especially voodoo, displays a positive rather than negative image of women:

“In Voodoo, there is no discrimination or sex, nor belonging. When you make part of the Voodooists, there is a female priestess, (called Mambo in Creole) or male priest (called Hougan in Creole). The difference of sex doesn't matter here. There are laws of God saying that males are as important as female priests. When the woman is on hold or on the protection of voodoo, they are all equal. In voodoo, all women in a ceremony, or the voodoo religion in my opinion, are equal.”

The Mambo is respected by voodooists; in general these women are very independent and can take care of themselves without depending on a man. Another participant explained that:

On the other hand, some others believe voodoo is an obstacle for women. Voodoo does not devalue women, but polygamy was developed in voodoo and devalues women. Voodoo can be a stigma for some women; some of them are feared in the communities because they can do “bad things”, or sorcery, and can therefore be marginalized in the community.

However, religion in general and voodoo in particular contribute to increase the social status of women in rural areas and give them a special place in the ceremonies and activities with the church and with the community. The Haitian mysticism is often a source of collective support and solidarity for women, even if some taboos and traditions tend to benefit men.

References

Joni Seager, *"Atlas of Women in the World"* ed., Earthscan, fourth education, 2009.

PAHO, WHO, *"Health in the Americas"*, Volume II, PAHO scientific Publication, No 622, p. 412-429, 2007

Information about Haiti

Our World: Views from Haiti. Opinion Survey, Survey conducted by Ipsos for ICRC, 2009

[http://www.icrc.org/Web/eng/siteeng0.nsf/htmlall/views-from-field-report-240609/\\$File/Our-World-Views-from-Haiti-I-ICRC.pdf](http://www.icrc.org/Web/eng/siteeng0.nsf/htmlall/views-from-field-report-240609/$File/Our-World-Views-from-Haiti-I-ICRC.pdf)

Information about Haiti found in <http://countrystudies.us/haiti/30.htm>

Information about Voodoo

<http://www.webster.edu/~corbetre/haiti/voodoo/overview.htm>

<http://www.religioustolerance.org/voodoo.htm>

**Appendix I: Reference Group Meeting on the Social Determinants of Health, the 05 May 2009,
Port-au-Prince, Haiti: Participants, agenda and minutes.**

	Participants
1.	Mr. Louise-Marie Boulos : Consultant et professeur d'épidémiologie Directeur du Centre d'Evaluation et de Recherche Appliquée (C.E.R.A.)
2.	Ms. Marie Dominique Beauzile Formatrice en sante de la reproduction, conseillère en question de genre. Directrice exécutive de la Fondation Haïtienne de Réhabilitation Sociale (FOHRS) Présidente du centre d'accueil « Foyer d'amour ».
3.	PH.D. en anthropologie de l'Université Laval au Canada
4.	Ms. Norma Perez Brisbois Research associate, Research Centre for Health Promotion (HEMIL) Faculty of psychology, University of Bergen
5.	Mr. André-Paul Vènor Médecin de santé publique en Haïti. Gestionnaire FSE- Santé au Centre de Gestion des Fonds Locaux de la Coopération Canadienne en Haïti
6.	Mr. Yves Saintil Directeur de PROFAMIL (l'Association pour la Promotion de la Famille Haïtienne) à Port-au-Prince.
7.	Directeur de l'Unité Santé, Nutrition et Education (USNÉ) du Ministère de l'Education Nationale et de la Formation Professionnelle (MENFP) membre du Comité Exécutif de l'Association de Santé Publique d'Haïti (ASPHA)
8.	Mr. Guy Marcel Craan Docteur en Médecine Consultant pour la Fondation SOGEBANK/CDC/MSPP
9.	Mr. Vincent Grammont Consultant et Coordinateur de terrain et développement stratégique
10.	Mr. Elysée Louissaint Médecin Généraliste, Obstétricien – Gynécologue

	Spécialiste en Santé de la Reproduction Analyste des données d'Enquêtes et Evalueur de programme
11.	Ms. Carla Morissette Responsable du comite d'appuie a la sante des femmes a PAP.
12.	Ms. Kethlie Estime Membre de l'association alliance pour la survie et le développement de l'enfant a PAP. (Konesans Fanmi)
13.	Dorfeuille Beatrice Médecin et directeur de l'association « Ouvres de Bienfaisance de Carrefour et Gresseir » a PAP (OBCG)
14.	Ms Berlande Secretary of the meeting/ Taking notes

**Appendix II: Reference Group Meeting on Social Determinants of Health:
IUHPE Project on the Social Determinants of Health in Very Poor Ruralities**

Venue - LE PLAZA HOTEL

Address - 10, rue Capois, Place des Heros, Port-au-Prince, Haïti

Mardi 05 Mai	Programme pour la journée
9.00 -9.30	Petit Déjeune
10.00 - 10-30	Début de la session Bienvenue et brève introduction du projet membres de Groupe de Référence par Mr. Boulos . Présentation de chacun des membres du Groupe de Référence
10.30 - 11. 00	Présentation du projet, Vue d'ensemble du projet, Le rôle du Groupe de Référence, Les objectifs de la réunion Par Norma Perez
11.00- 11.15	Questions et remarques ? Tous les participants
11.15 - 12.45	- Les déterminants sociaux de la santé dans les ruralités très pauvres, et principalement avec l'accent sur les femmes de l'enfant en âge de procréer. - Quels sont déterminants sont communes à la région? Une table ronde de discussion. Chaire M. Boulos et M. Grammont
12.45 – 13.45	Lunch
13.45- 15.45	Qu'est ce qui détermine la position sociale des femmes (mariées ou non) en âge de procréer vivant dans des ruralités très pauvres? Leur position dans le ménage et dans la communauté. Une table ronde de discussion, M. Grammont

15.45- 16.30	<p>Résumé de la discussion sur les déterminants sociaux de la santé dans les ruralités très pauvres. Que et comment devrait être mesurée?</p> <p>Une table ronde de discussion,</p>
16.30 - 17.15	Clôture et remerciement + petit souvenir de la Norvège

Appendix III: List of others participants in Haiti

Individual interviews in Port-au-Prince and Jacmel (South –East of Haiti)

1.	Clerisme Cleriste Sociologist and director of the « Centre de Recherche pour le développement »(CRD)
2.	Dr Ernest Désir Medical director and gynaecologist of PROFAMIL à Jacmel
3.	Nahomie Laurent Nurse working in the Mobile unit of PROFAMIL
4.	Marie Ange Noel Member Determined Women organization Social worker
5.	Alerte Laguerre Field responsible person from the gender and women rights ministry
6.	Evelyne Adonis Journalist and correspondent in various local radio stations.
7.	Wilda Pyram Children educator, founder of rural women organization.
8.	Carline Lafleur Social worker for a local women organization
9.	Myrlene Antoine Organizer and responsible person to give workshops about domestic violence and women rights up to 20 women in the region.
10.	Jean Claude Joseph Belizaire Photograph and Member of a men organization combating domestic violence against women. (AHDESE)
11.	Jean Elmiteau Auplan Ex Director of social affaires at Jacmel Responsible person of a men organisation combating domestic violence against women. (AHDESE)Responsable d'une organisation d'Hommes dans le Sud-est.
12.	Dinali Abeysekera, Women's Micro-Credit Coordinator the Association Ananda Marga Universal Relief Team (AMURT)
13.	Ruth Derilus, Human Resource and organizer of Community Relations, (Focus on Women) the

	Association Ananda Marga Universal Relief Team (AMURT),
14.	Amber Munger The Programs Assistant Coordinator for the Association Ananda Marga Universal Relief Team (AMURT),

Appendix IV: Cooperation with local and international Organizations

ADEMA²⁶ – Ansanm pou yon Demen Miyò an Ayiti ("Together for a better future in Haiti")

ADEMA is local association involved in supporting local development, primarily in two cities of the Northwest departments: Jean Rabel and Bombardopolis. This department is one of the poorest of Haiti. The food situation is dependent on external assistance and ongoing erratic weather conditions, particularly in the Lower North east. The environment is heavily degraded: the area is known for its production of charcoal; tracks and roads are very poor condition, which is a barrier to trade relations. Poverty, rural migration, crime, migration, erosion and desertification are some of the findings that has been done by the association Adema before it foundation in July 2005. The association has advocated development of a deep extensive involvement of the local actors, criticizing the aid of emergency to be insufficient and inadequate to really make a difference in the area. Adema cooperate with ID.

AHDESE - Devoted Men Association combating domestic violence against women

AHDESE is a devoted men's association combating domestic violence against women. This association through different activities educates/sensitize the general public, but especially others men, about violence problems. L'AHDESE was created in November 28, 2004. It is an association composed largely by men. This association is the result of several series sensitizing meetings around violence against women organized by "Fanm decide/Determined women" to men of the region. When women of the organization discussed about gender and violence suffered by their peers, they quickly realized that it would be better to cooperate with a men association to combat these violent acts in which men are the main perpetrators. Today they are a group of 48 members. They provide seminars to men in others regions in Haiti.

AMURT²⁷ - the Association Ananda Marga Universal Relief Team

AMURT-Haiti is an emergency relief and community development organization that builds the capacities of communities and community leaders in Haiti's Artibonite to plan, implements, and sustain their own economic, cultural, and social development. From disaster relief to sustainable development to human rights, our diverse initiatives focus on creating a community-based model of integrated planning and human/natural resource management in Anse Rouge and Gonaives

²⁶ For more info about ADEMA: <http://www.alterpresse.org/spip.php?article6943>

²⁷ More info about AMURT: <http://amurthaiti.org/>

Communes. AMURT-Haiti is a volunteer-based, not-for-profit, non-governmental organization that shares the principles of Ananda Marga Universal Relief Team (AMURT) Global.

AMURTEL has been promoting the skills of the AEPA monitors in small business development and financial planning through a series of training and other activities, and also has provided them with a Community Center for women education.

ID²⁸ : Initiatives development

ID was created in 1994 and its headquarters are in Poitiers, France.

Three ways to improve living conditions:- ease access to elementary supply such as water, health and education- allow the rise of income thanks to the development of agriculture-related activities and access to employment or loan;- widen the skills of the local actors of development

Work on a long term and with the respect of values by :- analyzing and studying specifically the context of the zones targeted before launching projects- helping people's autonomy, local development and the protection of natural resources- managing one's projects with demand for quality and result- training one's partners and making local communities responsible- transferring one's programs to a local partner

Femme Décidées – The Determined Women Association at Jacmel

The women organization "Determined Woman", founded was in 1999 (20 years of existence) and it present in five communes of Jacmel at the south-west region of Haiti.

The main activities and services offer these organizations are between the most important:

- To inform women about their rights,
- Enable women to better organize them,
- Address health issues that are of concern to women (children, contraception, etc.)
- Prevention and support women victims of violence (lawyer, home to mistreat women),
- Find mediators between husband and wife.
- They propose professional training to empower women in diverse areas
- They propose recreational activities or recreational days to women as well.

²⁸ For more info about ID: <http://www.id-ong.org/english/ID-in-english.htm>

PROFAMIL²⁹ - Association pour la Promotion de la Famille Haïtienne (Haïti Family planning association)

In the rural southeast and Port-au-Prince, Profamil's services are advanced by a team of health promoters and regular visits of a mobile unit. The community-based distribution point in the remote central part of the country offers Sexual and Reproductive Health information and primary care supplies. The promoters work five days a week and make an average of 8- 10 onsite visits daily. During the visits they provide contraceptive information and demonstrations; distribute free condoms; information about pregnancy, STIs, HIV/AIDS, and violence against women; and answer a variety of health-related questions. The promoters also help people to make appointments at the clinic.

PROFAMIL's philosophy – providing services to all clients (in access to reproductive health care for all people, particularly the poor, marginalized, and underserved), regardless of their ability to pay, and its outreach programme in remote communities – is a vital strategy to reach poor women and their families and make sure they have access to essential services. In the context of Haiti's endemic poverty, where women often do not go to clinics because they don't have appropriate clothes to wear, this approach ensures maximum take-up of services.

²⁹ More information about Profamil: <http://www.ippf.org/NR/rdonlyres/AA5603D1-FD01-4BD8-BFB5-AB44612AAB87/0/haiti.pdf>

Appendix V: Minutes of the Reference Group Meeting on the Social Determinants of Health

05 May 2009, Port-au-Prince, Haïti. Welcome, Introductions

La séance a commence par la Bienvenue de la part de M. Boulos et présentation de chacun des participants. Ensuite, la séance a continue avec une brève présentation du Projet SDHVPR, des objectifs et les attentes de la part du Groupe de Référence. Par après, nous avons commence à rentrer dans le vif du sujet et nous nos sommes focalises sur les principales questions concernant les DSH en zones rurales très éloignes et plus spécifiquement pour les femmes a la campagne. Tout au long de notre rencontre, il y a eu des difficultés à cerner les SDH pour les femmes et surtout à les détacher du contexte local pour plutôt nous référer à un contexte plus universel. La séance s'est tenue en français.

Voici un résumé des thèmes importants traites pendant cette séance.

Une introduction générale de la situation dans le pays :

Le groupe de référence d'experts pense que le gouvernement devrait jouer un rôle plus important dans ce dossier à l'appui du peuple. L'ONG travaillant dans les secteurs devrait prendre davantage en compte les besoins réels des populations, en particulier les besoins des femmes, avant de commencer un projet. Ils ont également souligné que dans les zones rurales, la santé des femmes est meilleure que pour ceux qui vivent dans certaines zones urbaines. Taux de mortalité des enfants dans les zones urbaines est plus élevé que dans les zones rurales. Dans les zones rurales, le problème principal est que les femmes enceintes n'ont pas beaucoup de moyens locaux de transport pour accéder à la clinique dans d'autres domaines.

Rôle de la femme

Les soins de la santé reviennent aux femmes elles sont les parties prenante de la famille.

- La femme joue un grand rôle au milieu familial en Haïti. C'est ce qui explique pourquoi les femmes sont en bonne sante aptes à prendre soins des autres.
- En milieu rural les femmes priorisent leurs enfants plutôt que de se supporter elles ont toujours tendance à s'oublier.
- Le sexe est l'un des facteurs également.
- Les enfants constituent un moyen de richesse dans les familles pauvres. C'est pourquoi elle assurer toujours l'éducation de leurs enfants.
- En milieu rural ce sont les feuilles qu'on utilise pour guérir. Très peu de personnes ont accès à aller consulte un médecin.

- Le système éducatif est l'un des facteurs qui contribue
- Même quand la femme est pauvre elle vit dans la dignité, valorisée, utile et solidaire c'est ce qui explique son bien être.

Pourquoi certaines femmes sont –elles plus malheureuses que d'autres dans les mêmes conditions socio-économiques ?

Elles n'ont pas les mêmes héritages et leurs lignes sont différentes également.

Au point de vu religieux représentant souvent le pilier de sa maison ou parfois sa communauté. La vie d'une femme active sera toujours différente à celle d'une femme inactive.

Quel est le statut social et civil des femmes les plus valorises et plus heureuses dans la communauté et foyer ?

Le mariage a une grande importance; les femmes mariées osent beaucoup plus que celles qui n'ont pas d'enfant,

- Les enfants sont vue comme une arme de revendication, ce sont des femmes au travail tandis que les célibataires s'engagent comme des leaders (urbain).
- L'environnement est également important, quand on est partie prenante dans son environnement on se sent mieux.
- L'enfant est un facteur de bonheur dans une famille.
- On constate que dans certaines localités le vaudou valorise les femmes car dans une cérémonie de vodou tout le monde est égale.
- Il y a également la relation sentimentale / le nombre de partenaires que contribue a leur quotidien et Bonheur.
- On trouve des femmes artisanales qui font ce que les machines ne peuvent pas produire; elles travaillent entre elles en participant aux activités des autres, s'en entre aidant.
- Apres des informations, beaucoup ont accepte la planification familiale car les hommes ne voulaient pas.
- Concernant les objectifs millénaires on voit que c'est un peu renforce, dans les zones rurales les femmes ont tendance à diriger la vie sociale telle que l'homme travail pour apporter le fruit a la femme.
- Il y a également une mauvaise répartition, on trouve la mort maternelle surtout après la naissance des enfants car il n'y a pas d'ambulance pour apporter de l'aide.

Conclusion

Cette étude est vraiment intéressante car les organisations internationales et nationales vont prendre le cas en considération en abordant les problèmes sous de l'angle plus réaliste. Porque ce projet puisse poursuivre sa course il faut que la communauté et le pays soient impliqués dans le développement de ceci. On doit donner accès au démunis plutôt qu'à la classe moyenne, Haïti est une casse de tête pour ceux qui veulent aider a cause des montagnes.

La condition médicale Haïti se repose sur la médecine traditionnelle, il y a une part d'obscurité dans tout cela quand les malades vont consulter un hougan pour quelque soit le mal. Il ne faut pas rester à attendre mais il faut attaquer pour la réussite de ce projet.

Appendix VI: Haïti`s Focus Groups questions guide

To follow the same methodology and directions in the field visits, the questions (guide) used for the focus groups in Haiti was inspired by the field work in Ghana. In these two countries women seem to have quite similar situations.

Introduction and example of the situation of two different women:

“Today we are going to talk about two Haitian 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. What does make the difference between these two women? What do you think?

Followed by a discussion with the group of women on the example and questions:

- Civil status: Children/husband/widowed
- How many children do you have?
- How do you feel in your community?
- How is your everyday life day? Activities? Tiredness?
- Starting the day. Feeling?
- Continuing the day. Evening – feeling?
- What do make you worry? What motivates you?
- Tell me about your husband.
- How is your relationship with your husband?
- What is his role? What is your role?
- Is he helpful? How shows he cares?
- How can a husband help a wife be healthy?
- What is it like to be a widow?
- Help and support: from whom?
- 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 do you feel?
- Know any really healthy women in your village?
- Why do you think is she more healthy?
- What do motivate you in life?
- Dreams and wishes for life
- When are you happy?

Appendix VII: Les questions en français pour le focus groups

Ronde de questions avec les femmes :

- Statut social : Enfants / mari / veuves
- Dites-nous ce que cela signifie pour vous d'y prendre part des activités dans votre communauté ?
- Comment se passe votre journée ?
- Démarrage de la journée. sentiment?
- Poursuite de la journée. Soirée - sentiment?
- Qu'est ce que vous inquiète?
- Qu'est-ce qui vous fatigue? Êtes-vous souvent fatigué?
- Qu'est-ce que ça fait d'être veuve? Aide et soutien?
- Enfant mort : Comment cela fait-il que vous ressentez lorsque vous perdez un enfant?
- Tout ce que vous savez de qui auraient pu empêcher votre enfant de mourir?
- Accouchement - comment est-elle un impact sur votre santé?
- Pensez-vous aller parler à quelqu'un si vous avez un problème?
- Besoin d'aide – a qui demande vous de l'aide ? Important? Pourquoi?
- Avez vous des amies passez vous des bon moments ensemble ?
- Comment sentez-vous avec eux?
- Parlez-moi de votre mari.
- Aide? Comment vous montre t-il qu'il s'en soucie de vous?
- Comment un mari peut aider sa femme à être en bonne santé?
- Est-ce que votre partage ce qu'il gagne avec vous?
- Partagez-vous ce que vous gagnez avec votre mari?
- Comment est la relation avec votre mari ?
- Votre mari vous aide ou vous soutien ?
- Quel est votre rôle ? quel est son rôle dans la famille ?
- Qui est responsable de la nourriture à la famille?
- Est-ce une bonne chose d'avoir un mari? Pourquoi / pourquoi pas?
- Est-ce qu'un mari peut être un problème pour la femme? De quelle manière?
- Souffrez-vous du corps / mal souvent?
- Ce qui vous rendez malade?
- Ce qui vous tien en Bonne santé?
- Qu'est ce qui vous rend heureuse ?

- Qu'est ce qui vous motive ?
- Quel sont vos rêves et souhait pour la vie ?