

**Centre for International Health**

**Making the links between women's health and women's lives in  
Papua New Guinea: Implications for policy and health care delivery**

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Doctor of Philosophy  
of  
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## Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature:  .....

Date: 1 September 2009 .....

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## **Abstract**

International perspectives of women's health have drawn on biomedical solutions and pathology-based aspects, and one of the main components of a changing and evolving definition of women's health is to provide an alternative to these perspectives that are grounded in the western framework. There has been a tendency by researchers and health professionals to utilise approaches that prioritize only one dimension of woman's lives such as their biological, reproductive or maternal roles to the detriment of understanding the complexity of women's histories, cultural contexts and lived experiences. The overall goal of this study was to investigate women's health within the socio-historical context of Papua New Guinea (PNG) to firstly, understand the self-identified health concerns of women, secondly to examine the critical points in the lifespan for effecting positive change in the health status of women and finally, to ascertain if the divergence between the perceptions of service providers and the real needs of women can be reduced.

The study was set in Patigo (Wosera sub-district), in the East Sepik Province, a rural area and one of the least developed areas of Papua New Guinea. There is a heavy reliance on subsistence production for household consumption, high infant and maternal mortality and morbidity rates, limited cash earning opportunities and low per capita incomes in the district. Women conduct most of the daily subsistence and domestic duties. Women's health and social development statistics are poor in the Wosera and it is easy to see solutions as either medical or matters of health education. However the health status of women reflects the complex and changing social and structural conditions of women's lives and in particular, the gender-based inequalities that women face are fundamental variables affecting health.

This study was conceptualised using an interpretive qualitative methodology within an ethnographic and rights-based framework, based on the real experiences of women's daily lives. The study was conducted during a four month study period from July to October 2005 and in February 2006. The investigation strategy utilised a within-method triangulation approach, using a combination of qualitative and participatory methods. To enable an understanding of the diverse health needs of

women and the key determinants of health across the lifespan, the socio-cultural and gender perspectives of young, adult, older women were examined. Discussions were also held with young and adult men and key community members considered to have specific knowledge of women's health issues.

Women's narratives show that reproductive health problems did not figure prominently among the health issues women described. Health was related to the social and material circumstances of women's lives. It was discussed as a social and cultural experience, not an isolated and individual condition and all women prioritized people and relationships. Women were part of a nexus of complex social relationships that were socially and historically layered with links to many generations. The types of relationships women experienced were influenced by personality, faith and socio-cultural values.

The relationship between women's health and the social conditions of their lives is given token recognition in health policy and women's health programming in Papua New Guinea. Women face a health system that pre-imposes a narrow definition of women's health to the detriment of gender issues and women's empowerment. The findings reveal that in the Wosera women's work and the physical burden of women's roles, marriage and risk and experience of violence, and an unresponsive and inappropriate health service were major risk factors and barriers to women's health. Based on this finding a holistic and rights based approach to women's health policy, programming and advocacy is proposed. It is argued that the daily inequalities, discrimination and oppression that women face in their everyday lives, affects their ability to achieve the right to health and a host of interrelated rights such as the right to education, right to food and nutrition and freedom from discrimination.

The study also emphasized the relevance of psychosocial constraints for women's health. Psychosocial factors, linked to material circumstances and individual behaviour, exerted a powerful influence over health and affected a woman's ability to cope with difficult life circumstances. Feelings of powerlessness, helplessness and stress-related disorders among women were related to the gender inequalities that worked to perpetuate the low status of women throughout the life span. Women who could not count on male support (husbands, male relatives, sons) and were the target

of constant abuse and neglect were identified to be particularly vulnerable and at a risk of depression and stress.

The study also documented that women throughout the life cycle displayed inherent resilience and adopted different coping strategies for dealing with the demanding and complex circumstances of their lives but some women were better positioned than others to cope. The active coping mechanisms of women showed a strength, assertiveness and resourcefulness in response to constant hardship. Resilience was enhanced when women had access to social networks and supportive social relationships and were therefore better able to deal with constraints to health. A particular threat to coping was found to result from a woman's experience with gender constraints, violence and lack of social support.

The findings from this study contribute to a rethinking of the traditional biomedical approach to women's health research. The study challenges the worldview that prioritizes reproductive health over an approach to women's health that concerns the totality of women's lived experiences throughout the life span. This study calls for the need to increase the focus of research on the application of psychosocial and rights-based perspectives to understand the diversity of women's health-related experiences, the complexity of their social relations and the relationship between challenging social and material circumstances and health outcomes.

Recommendation and implications for further research, education, policy, advocacy and programming action, are proposed and discussed.

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## List of Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHW	Community health worker
CSW	Commission of the Status of Women
FGD	Focus group discussion
FSVAC	Family and Sexual Violence Action Committee
GDP	Gross domestic product
HEO	Health Extension Officer
HPV	Human Papilloma Virus
KWP	Kup Women for Peace
MCH	Maternal and child health
MDGs	Millennium Development Goals
NGO	Non-government organisation
ODA	Overseas development assistance
PHC	Primary health care
PMV	Public motor vehicle
PNG	Papua New Guinea
PNGIMR	Papua New Guinea Institute of Medical Research
SHP	Southern Highlands Province
SWAp	Sector wide approach
VBA	Village birth attendant
YWCA	Young Women's Christian Association

## List of Pidgin words

<i>bik meri</i>	an esteemed woman
<i>fri long.....</i>	free to.....
<i>go raun long taun</i>	go to town
<i>Helti</i>	Physically healthy
<i>inap long stretim</i>	able to fix something / cope
<i>ino inap mekim wanpela samting</i>	unable to do anything
<i>kaikai blong stoa</i>	food purchased from a tradestore
<i>Kalabus</i>	jail
<i>Lapun</i>	old
<i>marasin meri</i>	medicine woman
<i>meri blong maket</i>	a woman who [sells produce at] markets
<i>Meri Seif Ples</i>	Safe house for women
<i>Nogut</i>	bad
<i>samting nating</i>	unimportant, meaningless
<i>sot long planti samting / painim hat long moni</i>	poverty / financial difficulties
<i>stap gut</i>	in a good state / a good life / good sense of wellbeing)
<i>stap long strong long mi yet</i>	personal strength
<i>stretim bel blong em</i>	soothe the anger of another
<i>tanim tok</i>	to change what was said
<i>tingting bai bagarap</i>	unable to think straight
<i>tingting planti</i>	thinking too much
<i>tok beksait</i>	to talk behind a person's back
<i>tok pisin</i>	Pidgin (Melanesian)
<i>Wari</i>	worry
<i>wari olsem tingting save kam strong</i>	stress
<i>wok blong ol meri</i>	women's work
<i>toktok bai muv</i>	what was said will be spread
<i>Yumi Lukautim Mosbi Projek</i>	Let's Look After Port Moresby Project

# CHAPTER ONE

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## INTRODUCTION AND OVERVIEW

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### **1.0 Introduction**

This thesis examines rural Papua New Guinean women's perceptions of their health. As one of the few studies of its type in Papua New Guinea, this research extends beyond a biomedical and reproductive view of women's health, and examines women's health throughout the life span within the social, economic and cultural context of women's lives. The findings reveal that the inequities women face in their daily lives impact on their right to health and their ability to cope with challenging circumstances.

This chapter introduces the thesis and provides a detailed background to and justification for the study and also includes a literature review. It begins with an overview of the development setting and health context of the study and a review of relevant international women's health literature. An overview of the study setting and the professional context of the researcher and interest in Papua New Guinea is also provided. The chapter concludes with an examination of the limitations of the study, a discussion of the significance of the research and an overview of the thesis.

### **1.1 Background to the study**

Papua New Guinea was colonised by Germany and Great Britain in 1884 and administered by Australia from the early 1900s until independence in 1975. Papua New Guinea (PNG) comprises the eastern half of the island of the New Guinea mainland, the Bismarck archipelago (consisting of the island groups of Manus, New Britain and New Ireland), the islands of Bougainville and Buka; the Louisiade archipelago and several hundred smaller islands or island groupings. The nation of 6.2 million people is diverse in languages, which number around 800 tribal groups, arguable the most socially and linguistically diverse country in the world (Dinnen & Thompson, 2004). Although Papua New Guinea was mapped and named by colonists

as a single country, clans and communities continue to act as autonomous units. The concept of nationhood is problematic in the absence of a shared sense of identity among the citizens of PNG (Alpers, 2005; Dinnen, 2002).

### **1.1.1 The development context**

Social and economic development in PNG is heavily influenced by the country's geographic characteristics, notably high, densely populated complex mountain chains, swamps and rivers, remote islands and tropical climate. There are currently no roads linking the capital Port Moresby with the north coast or highlands where the majority of people live. Internal transport is by air and sea; and this makes the movement of goods and people expensive. Eighty five percent of the population is rural and engaged in a subsistence economy, farming crops on customary land holdings along with a range of cash crops, including coffee, tea, copra, cocoa, and palm oil. Gross National Income per capita is low at US\$850 (AUS\$925) (World Bank, 2009). However this fails to show economic disparity in the population and rural incomes are estimated to be substantially lower. Although disaggregated economic data is difficult to obtain, it was suggested in 2001 that the average annual income in rural communities was US\$300-\$350(AUS\$325-AUS\$380) per person (United Nations, 2001).

The PNG economy has achieved positive growth since 2003 and the government has recorded budget surpluses primarily due to rising commodity prices (Corner, 2008). Government debt dropped from 47.6% of Gross Domestic Product (GDP) in 2005 to a current level of 30%. Government revenue is heavily dependent on tax receipts from oil and mining projects and as the global economy contracts, there has been a slowing of the PNG economy. The price of gold, copper and oil has fallen and the employment index for mining and agriculture has dropped 10% since mid 2007 (Auster & Robinson, 2008). It is forecasted that the Government budget for 2009/2010 will decrease in revenue by 25% (Cutback fears, 2009). Inflation has increased by 5% since 2007 and consumers are paying high prices for basic commodities and services. Improvements have been made in the country's economic status, however the 2007/2008 Human Development Report ranks PNG, 145th of 177 nations on broad human development measures and indicators (UNDP, 2008), hindered by inadequate and deteriorating infrastructure. Papua New Guinea is one of

the least urbanised countries in the world, with only 13% of the population living in cities in 2006 (UNICEF, 2008). Sixty percent of people are without access to an improved water source (World Health Organisation / Western Pacific Regional Office, [WHO/WPRO], 2008).

Problems of lawlessness are a constant theme in current accounts of Papua New Guinea. Serious outbreaks of inter-group conflict occur in parts of the country and the spread of lawlessness has tended to follow larger patterns of development (Dinnen, 2002). Physical, sexual and emotional violence against women (Amnesty International, 2005; Lewis, Maruia & Walker, 2008; Toft, 1986), politically motivated violence (Hinton, Kopi, Apa, Sil, Kini, Kai, et al., 2008; Standish, 1996) and the growing incidence of corruption and fraud among the political elite (Dinnen and Thompson, 2004), the politicisation of the public service and lack of transparency in business and other dealings contribute to Papua New Guinea's law and order problems. Papua New Guinea is ranked 151 of 158 countries in the Transparency International Corruption Perception Index (Transparency International, 2008).

There is a common view among Papua New Guineans that many leaders are corrupt, they accept goods for favours, steal public money and property and engage in a range of other fraudulent activities (Pitts, 2001). The timber trade for example is plagued by high rates of illegal logging by foreign owned companies from Malaysia, Indonesia, the Philippines and Singapore (Alpers, 2005) and can be used as a proxy for the incidence of corruption. In Papua New Guinea it is estimated that 70% of logging activities are illegal (UNDP, 2008). Although government is appearing to address alleged corruption with commissions of inquiries into massive public fraud, no arrests or prosecutions have occurred (Pitts, 2001).

### **1.1.2 Aid in Papua New Guinea**

Papua New Guinea is heavily aid dependent. The ratio of overseas development assistance (ODA) to GDP is approximately 7% (compared with 0.9% in Indonesia) and makes up 18% of total government expenditure (Corner, 2008). Because of the two countries' proximity, colonial history, and continuing special relationship, Australia wields enormous influence and is Papua New Guinea's largest foreign

donor. Papua New Guinea and the Solomon Islands account for 70% of Australia's aid expenditure in the Pacific, assistance which was expected to grow in 2008-2009 to AUD\$999.5 million (AusAID, 2008). It is estimated the Australian Government spent AUD\$389 million in Papua New Guinea in 2008-2009. The size of this assistance alone allows AusAID to dominate the development and political discourse.

Being heavily aid dependent creates an imbalance in the donor-recipient relationship so that development assistance to PNG and other Pacific countries is directed towards a few, specific sectors (Social and Economic) that reflect the funding dominance and spending priorities of Australia. In Papua New Guinea, Australia concentrates its funding on institutional social infrastructure and services and strengthening projects, and within this, half of the money (33% of total aid) goes towards governance activities, including government administration, legal and judicial development, and public sector financial management (Organisation for Economic Cooperation and Development [OECD], n.d). Good governance is a starting point on which other sectoral objectives are built (AusAID, 2004). Although bilateral assistance for health and education increased slightly in 2006, it decreased as a proportion of total aid (OECD, n.d).

Despite the severity of human rights abuses in PNG (see Amnesty International 2005; Human Rights Watch, 2005) the Australian Government does not formally raise human rights concerns with PNG and AusAID publications do not overtly consider human rights an issue (Asian Centre for Human Rights, 2008). Human rights was not mentioned once or discussed in relation to poverty reduction and sustainable development in the PNG-Australia Development Cooperation Strategy 2006-2010 (Asian Centre for Human Rights, 2008; see AusAID, 2007). A recent change in government in Australia may see a political climate that is more conducive to the integration of human rights in development discourse and practice. A five day regional consultation for Pacific Members of Parliament on integrating international human rights standards into national policy and law was held in Brisbane from 15-19 December 2008. On opening the consultation Australia's Parliamentary Secretary for Pacific Island Affairs said that the Australian Government was committed to working with Pacific Island states to promote and uphold human rights in the region. The

Honourable Duncan Kerr said that the protection of human rights was important to the Pacific region's political, social and economic development and the Australian Government is committed to working with Pacific neighbours on practical measures to improve human rights standards and the supporting institutional infrastructure across the region.

Supply-driven aid, lack of consistency between country priorities and donor strategies, lack of buy-in by donors into the country systems and processes are key challenges to aid effectiveness and development results. In order to put in place measures to improve the coordination and management of aid, PNG has been active in implementing the Paris Declaration on Aid Effectiveness (2005). The PNG Commitment on Aid Effectiveness was formally signed by the Government in July 2008 and monitorable targets and actions have been set by the PNG Government to improve aid effectiveness for the period 2007-2012.<sup>1</sup> The PNG Commitment does not however include a reference to gender equality (Corner, 2008). Attention to gender equality and women's empowerment in Papua New Guinea, where the status of women is low, is relatively recent and not yet supported by significant policy development.

### **1.1.3 Profile of health in Papua New Guinea**

The national health system is based on the primary health care approach with a network of aid posts, sub-health centres, health centres, rural, national and provincial hospitals and urban clinics. A combination of government, churches and private organisations provide health services in PNG. About 60% of health facilities are provided by churches. Besides the formal health services, village health volunteers, traditional birth attendants and traditional healers also provide health services, especially in some remote rural communities (United Nations, 2001). Dinnen (2002) reflects that the formal law and justice sector in PNG is geographically as well as socially distant for many people, and the health system can be similarly critiqued. Services are unequally distributed and concentrated in urban areas (Haley, 2008). There is ineffective implementation, monitoring and evaluation of national policies

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<sup>1</sup> Although alignment with national procedures is integral to the Paris Declaration, there is reluctance on the part of donors however to use national systems for procurement and financial management due to concerns about transparency and accountability.

and guidelines at the provincial and district levels. The health system is poorly managed and suffering from a shortage of resources and infrastructure. This is not unexpected given in 2005, the country's total health expenditure as a percentage of GDP was just 3.2%, the lowest among all Pacific countries (WHO/WPRO, 2008a).

The ratio of doctors and nurses to patients is extremely low at 1.26 and 15 per 10,000 respectively (WHO/WPRO, 2008). National health service delivery has been seriously compromised by fiscal crises and instability, large scale inter-group violence, personnel turnover, corruption and general breakdowns in communication and transportation (Hammar, 2008). Moreover, while the 1995 Organic Law on Provincial Governments and Local Level Governments (covering PNG's decentralised system of government) was intended to improve service delivery, evidence suggests that the new Law has had the opposite effect. It is generally accepted by government officials that the Organic Law suffers from serious conceptual flaws, has been poorly implemented and there is a lack of understanding of roles and responsibilities across all levels of government (Government of Papua New Guinea, 2004).

The health sector receives major inputs from donor partners and the government has established a "Sector Wide Approach" (SWAp) to donor coordination to support the government's National Health Plan which sets the standards for addressing priority health problems. This shift towards working through partner government systems pre dates the Paris Declaration on Aid Effectiveness and was one of the first to be developed in the Pacific region. However, despite the large volume of assistance provided, it is suggested that recent results in both the health and HIV/AIDS SWAps have been disappointing (Corner, 2008).

In rural Papua New Guinea the formal health care system, consisting of a network of aid posts, health centres and district hospitals exists alongside traditional medical practices. A combination of government, churches and private organisations provide health services. Village health volunteers, traditional birth attendants and traditional healers also provide health services in some rural communities (United Nations, 2001). Some health gains have been made. Although hard to attribute to individual factors, UNICEF figures showing a downward trend in child mortality (1990 –



67/1000, 2008 – 53/1000) and there is every indication that this is starting to accelerate (A/Prof Trevor Duke, Director Centre for International Child Health - personal communication).

Despite a political commitment to primary health care (Connell, 1997) and some health improvements, progress in primary health care provision has been slow. Infectious diseases, such as pneumonia and diarrhoea still claim the lives of many infants and there are serious public health risks from endemic diseases such as malaria, and an emerging HIV/AIDS epidemic. The scarcity and maldistribution of human resources for health has not been addressed effectively, due to other district and local government priorities, almost all rural health services in the country are underfunded and medical supply and drug procurement and distribution face many challenges and “stock-outs” are common occurrences (Hammar, 2008).

Papua New Guinea is now in the position of having the highest incidence of HIV/AIDS in the Pacific region. With a current prevalence rate of 1.6%, Papua New Guinea accounts for 91% of HIV cases in the Pacific (WHO, 2006a). The National Aids Council Secretariat (2008) reports that the prevalence of HIV is increasing in young women and is twice as high as among men of the same age cohort. There has been a dramatic rise in tuberculosis (TB) with a prevalence rate in 2006 of 513 per 100,000, the highest in the Pacific (WHO/WPRO, 2008a) and HIV/AIDS poses an additional threat of susceptibility to TB. Malaria is endemic in many coastal areas and is the third leading cause of hospital admissions and death in PNG (WHO/WPRO, 2008). Preventable infectious diseases remain the main cause of illness and death. The under-five child mortality rate is the highest in the Pacific at 73 per 1000 births,<sup>2</sup> and in 2006, Papua New Guinea accounted for over 90% (14,000) of the Pacific’s under-five deaths (UNICEF, 2008).

The life expectancy of women is estimated to be 61 years (WHO, 2006). Women’s morbidity and mortality rates in PNG are the highest in the Pacific region (870/100,000), compared with 236/100,000 in the Solomon Islands and 50 per 100,000 in Fiji (WHO/WPRO, 2008a). A woman from Papua New Guinean is 200

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<sup>2</sup> The Solomon Islands under-five mortality rate is also 73/1,000.

times more likely to die in childbirth than a woman in Australia (4/100,000). Contraceptive prevalence is poor at only 26% (UNICEF, 2008). Female literacy is low at 46% and only 6% of the female rural population have completed an education level of Grade 10 or above (National Statistics Office, 2002).

Women face unequal opportunities in education, income generation and access to economic resources and property, and widespread gender inequity leaves girls particularly vulnerable to abuse, exploitation and violence. Domestic and family violence, rape and gang rape and the torture and murder of women suspected of sorcery are distinctive features of violence against women (AusAID, 2008a). Early marriage is not unusual, and it occurs under the pretext that the marital relationship will improve a woman's social and economic security. A girl in Papua New Guinea can be two or three times younger than her husband (Hammar, 2008). Repeated childbearing, poverty and manual labour all have an impact on the health of women and their families. The practice of brideprice and polygamy is prevalent, reinforcing widespread expectations of patriarchal dominance and male control over women (AusAID, 2008a). These practices are significant determinants of HIV transmission in Papua New Guinea (Lewis, Maruia & Walker, 2008) and create a level of economic dependence and vulnerability that contributes directly to women's inability to assert control over their lives (Freedman, 1999). It is common for women to be excluded from decision-making at all levels. The political landscape is dominated by men and fewer than 2% of the candidates in any of the Papua New Guinea national elections have been women.<sup>3</sup>

It is in this context that the National Department of Health (2000, p.46) states in the National Health Plan 2001-2010 that "the status of women in the community, men's attitude towards women's health needs and the burden of family commitments often lead to poor access to available health services. Further, women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate health services to women." Despite this recognition, women's health remains aligned with safe motherhood and reproductive health, with the overall goal

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<sup>3</sup> Honourable Dame Carol Kidu is the only female Member of the 109 seat parliament. At the time of writing a legislative change has granted three interim seats to women in the National Parliament to be held until the national elections in 2012.

to “prevent illness, suffering and deaths among women in PNG through gynecological, pre- and post-natal care and supervised deliveries” (National Department of Health, 2000, p.48). High female mortality rates continue to be addressed by only applying biomedical solutions to what are in actuality complex socio-cultural entrenched health problems.

#### **1.1.4 Social relationships and the links to health in Papua New Guinea**

Kinship networks and social relations are fundamentally important to all communities in Papua New Guinea. People are part of a complex nexus of social relationships that can span many years and generations and which are infused with cultural norms, spirituality and personality (Underhill-Sem & Peutalo, 2006). Many social relations are inherently gendered and must be understood within the social, cultural and development context in which they are experienced. The negotiation of these social relationships lies at the heart of gender equality in Papua New Guinea.

There has been much debate and analysis in the Melanesian literature about the relationally-orientated nature of personhood. It is beyond the scope of this thesis to review the debate but it is relevant to note that “dividuals” are directed and moved by the relationships in which they are embedded and the network of consanguines and affines which produce them (Strathern, 1988, Biersack, 1991; Mallet, 2003; Wardlow, 2006). This notion of personhood, while under pressure from a commoditized society to change from a relational to more individualistic form (Stewart & Stathern, 1998) positions a woman in any given context in terms of the particular relations that constitute her (Mallet, 2003), whether that be their relationship with friends, in-laws, husbands or dead relatives.

These social relationships are however inherently gendered, increasingly negotiated and redefined. Josephides (1991) argues that women are not simply “sociocentric” or enacting social patterns without any agency. At times in opposition to cultural expectations and gender norms women resist and work to change the relationships of which they are a part and as Strathern (1988), would suggest, of which they are made. Wardlow (2006) describes this as negative agency, and expression of a more individualized self in which a woman separates herself from the desires and plans of others and refuses to commit her bodily energies to them.

Studies in areas of large agriculture and resource development in Papua New Guinea (Koczberski, 2002; Macintyre, n.d) have shown that when women can increase their access to cash, they are better able to provide for their families on their own terms and to reassert their economic power, autonomy and identity within their households and communities. Koczberski (2002) found that a woman's view of being a full woman/person was associated with her role in the domestic sphere, where she could show herself to be a good mother, wife, sister, and in-law, and in doing so assert her sense of personhood.

The pervasiveness of sorcery is a significant indicator of the nature of social relationships. In many societies in Papua New Guinea sorcery is perceived as the cause of acute and unexplained illness and death. In all cases there is human culpability and an expression of bad social relationships (Ayers Counts & Counts, 2004). A "good" death is one of an elderly person that takes place with their acquiescence and under their control (Ayers Counts & Counts, 2004). A premature death is a result of violence or *posin* (sorcery). Since it is caused by human action it is therefore important to ascertain the underlying cause of the illness or death.

## **1.2 The global context of women's health**

This thesis utilises the Alma Ata Declaration's definition of health which sees health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO & UNICEF, 1978, p.15). Health is a fundamental human right and social goal whose realization requires the action of many other social and economic sectors in addition to the health sector (WHO & UNICEF, 1978). This definition of health is linked to the concept of wellbeing, a concept used to describe the 'whole person' and although definitions vary, wellbeing is often examined in terms of happiness and satisfaction with life (Blanchflower and Oswald, 2004; Hildebrandt and Kelber, 2005).

By explicitly including the mental and social dimensions of health, the definition of health was radically expanded, and included the roles and responsibilities of health professionals and their relationship to the wider society (Mann, Gostin, Gruskin, Brennan, Lazzarini, & Fineberg, 1999). Responsibilities of governments also extended beyond the provision of essential services to tackling the determinants of

health, such as the provision of adequate education, housing and favourable working conditions. This has meant governments are obliged to take responsibility not only for the prevention, treatment and control of diseases but for the progressive correcting of conditions that may impede the realization of health (Braveman & Gruskin, 2003).

Though regarded by critics as an unrealistic and unmanageable proposition in the context of limited resources, a broader definition of health is especially relevant for understanding women's health. A woman's physical state cannot be separated from her mental and social wellbeing. As Fathalla (1997, p.5) observed, "a woman who is carrying an unwanted pregnancy cannot be considered healthy simply because her blood pressure is normal and the foetus has a normal biophysical profile." The health of women is intrinsically linked to the conditions under which they live. Policy and intersectoral coherence, multi-component interventions and collective action by policy-makers, practitioners, non-government organisations and civil society is therefore essential to improve health (Commission on the Social Determinants of Health [CSDH], 2008).

A preference for male-centred models of health (WHO, 2003) has resulted in biased and unbalanced research, a misrepresentation of specific conditions and a neglect in clinical practice and services which cater for the needs of women (O'Donnell, 2004). An implicit use of the white, middle-aged male as the normative frame against which to compare women's health (O'Donnell, 2004; Weisman, 1997) constructs male experiences of illness as "typical" and all others (females) "atypical" and as deviations from the norm. This would suggest that illness experiences are biologically and socially neutral and there is little regard for gender differences in illness behaviour and presentation of illness (O'Donnell, 2004). Furthermore, there is a tendency to emphasize biological or sex differences as explanatory factors of wellbeing and illness (Mahasneh, 2001). Normal female experiences, such as pregnancy and menopause, have been traditionally constructed with the male medical model as disease processes that can be cured or controlled (Timmerman, 1999).

### **1.2.1 Women's perceptions of health**

Health perceptions are the ways in which people comprehend and reflect on their health. These reflections determine people's health behaviours and their decisions about when to ask for help (Mahasneh, 2001). Brown (1998, p.343) states that "there is little research on what women themselves deem to be their health concerns" and he claims that we know even less about "the health issues, concerns and experiences of women who are not white and middle class."

Chapter 3 offers a more detailed analysis of the literature and documents that women's perceptions of themselves not only affect their health but are paramount to understanding women's perceptions and understandings of their health. Research conducted by the Population Council in Giza has shown that it is difficult to promote the cause of better health for women in the absence of understanding how women estimate their own worth. Insofar as this estimation mirrors society's devaluation or valuation of women, women's health perceptions serve as markers of inequality (Population Council, 1997).

The low social value of women not only distorts women's health perceptions, but can increase their vulnerability and influence access to health care. Renu (1996, p.64) discusses that the underlying assumption of the SARTHI women's health project in India was to overcome stereotypical images of women and the "layers of negation and devaluation" that women experience. By prioritizing women's own concepts of health, women are given the opportunity to define and work with what they perceive as important health issues, which might include aspects of reproductive health, but as will be discussed in Chapter 3, includes a breadth of consistently unconsidered issues, such as the affect of gender roles and responsibilities, economic constraints and workload on health. This in turn impacts upon the knowledge about women's health that is created and disseminated.

An ongoing attempt is being made to redefine scholarly interpretations of women's health. Over the last decade there has been a growing body of international literature emerging from studies, often with marginalized women, in diverse social contexts including North and Latin America, Africa, Australia, the Middle East and South

East Asia. This has contributed to a more in-depth examination and documentation of what women deem their health concerns to be.

Epidemiological research is valued for heightening public awareness of risk factors associated with disease, however it has been challenged for its disciplinary boundaries in what it can reveal about women's health (Bannister & Schreiber, 2001; Link and Phelan, 1995; Macintyre, n.d; Schultz & Lempert, 2004; Wong, Li, Burriss & Xiang, 1995). In the United States, Canada and the United Arab Emirates for example, investigators have centered their work on eliciting women's definitions of health to understand the issues affecting women as a social group (Canales, 2004; Leipert & Reutter, 2005) or at a specific point in the life span, such as with young adult women in Canada (Bannister & Schreiber, 2001) and Australia (Lee & Gramotnev, 2007) respectively.

Several authors have espoused a broader definition of women's health for its recognition of the diversity of women and the differences in experiences throughout the life-cycle. In order to understand the spectrum of women's views Mays, Zimet, Winston, Kee, Dickes & Su (2000) examined adolescent and adult women's knowledge and beliefs about genital warts, human papilloma virus (HPV), cervical cancer and pap tests. Although focusing on a specific dimension of women's health, methodologically the study was unique in its attempt to compare the perspectives of both young and adult women to improve service provision and health promotion activities. Craft (1997) also supports an examination of women's health through the life cycle, and as Chapter 3 discusses, this is due to the recognition that the health status of a woman in one phase of her life affects not only the subsequent phases but also the lives of existing and future children.

Moss (2002) explains that a dynamic and life course perspective that takes into account foetal, childhood and adolescent precursors to adult health, as well as cohort experiences, contributes to a more meaningful grasp of the social and economic patterning of women's health. Adolescence for example marks the developmental transition from childhood to adulthood and is a time when many biological, social, economic and demographic events set the context for adult life. Despite this there has been very little exploration of adolescence using a definition of health in its

broader sense, whereas epidemiological methods are being increasingly used to examine socioeconomic pressures facing young adults (Lee & Gramotnev, 2007). Nearly a decade ago the World Health Organisation (2001) called for a thorough examination of the constraints which make young women vulnerable to (in this case) sexual and reproductive ill-health in different settings and the associated community and social forces which create gender imbalances and limit choice.

Women's health is not separate from other aspects of life or independent of the social and political context (Kelaheer, Baigrie, Manderson, Moore, & Williams, 1998). Women often describe the holistic nature of their health, the interconnectedness of mind, body and spirit, the interrelationship between the physical, social and the psychological (Kasle, Wilhelm & Reed, 2002; Thurston & Meadows, 2004; Weerasinghe & Mitchell, 2007; Winslow & Honein, 2007). Studies with postnatal and antenatal Black Caribbean women in Britain show that women tend to privilege social and psychological (such as stress and lack of emotional stability) over biological explanations for perinatal depression. Psychological distress was a result of "overload," the cumulative effect of dealing with ongoing financial pressures and difficulties in personal relationships (Edge & Rogers, 2005).

Women's perceptions of health are reported to be multidimensional, complex and inherently social among populations of women in South East Asia (Defo, 1997), United Arab Emirates (Winslow & Honein, 2007), the United Kingdom (Walters & Charles 1997), Ecuador (Schoenfeld & Juarbe 2005), North America (Polakoff & Gregory, 2002; Shulz & Lempert, 2004) and Ghana (Avotri & Walters, 1999). Women's perceptions of health are also based around the experiences of their day to day lives, the multiple roles they undertake and their material circumstances (Leipert & Reutter, 2005; Hildebrandt & Kelber, 2005; Kaddour, Hafez & Zurak, 2005). The relational and interpersonal contexts of a woman's life are as important as material circumstances when considering the ways in which women define health. The construction of family relationships, social support and social isolation are examples of social realities that determine women's experiences of health and wellbeing (McDonald & McIntyre, 2002). Strategies to improve women's health must be considered from a relational perspective, on either the personal or social levels (Kasle, et al., 2002).

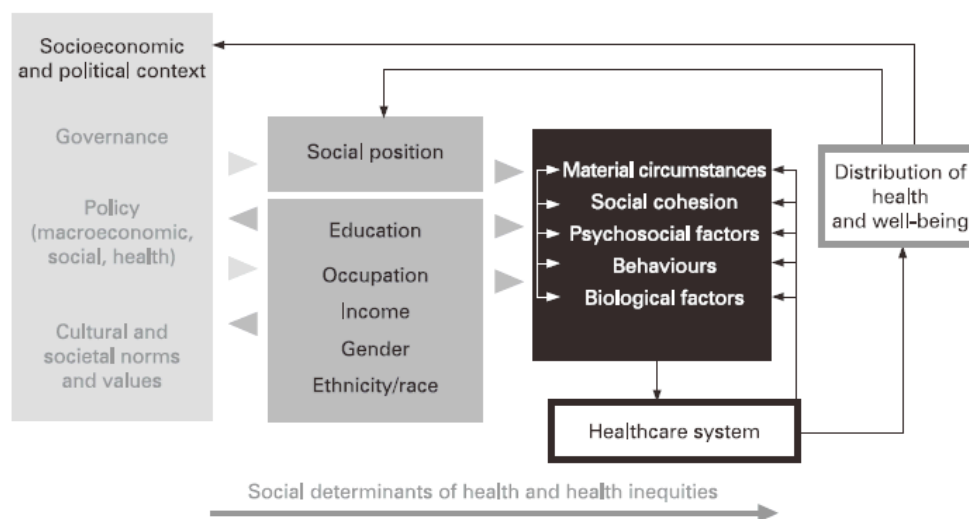


### **1.2.2 The determinants of women's health**

A major development in women's health has been the recognition that health status cannot be simply attributed to biological and genetic differences or access to health care. Rather, health is determined by a complex layer of intertwined social, cultural, behavioural and psychosocial factors. Discussed in greater detail in Chapters 4 and 7, these factors, shaped by the socio-structural context of people's lives, include; level of education, economic status, housing, environment, age, social support, discrimination, value of women and powerlessness (Cohen, 1998; Denton, Prus, Walters, 2004). Anderson, Scrimshaw, Fullilove, Fielding & the Task Force on Community Preventive Services (2003, p.12) describe the determinants of health as those societal conditions which affect health and that can potentially be altered by social and health policies and programs.

For example, education level affects the resources women can access and their capacity to avoid risk. A higher level of education is associated with an improved standard of living, greater economic power, better access to social support and capacity to negotiate social institutions and services. Compared with men, lower education levels among women is associated with a higher risk of low coping ability (Kristenson, 2006). The knowledge and skills gained through education enable women to enjoy better health due to the degree with which they have control over their lives, improve their status in the family and become more receptive to health education messages or more able to communicate with and access appropriate health services (Solar & Irwin, 2007). There is also a close correlation between women's empowerment through education and reduced maternal and infant mortality and improved family life (Craft, 1997; Gunaserera & Wijesinghe, 1996; UNICEF, 2009). The Commission on Social Determinants of Health suggests a framework (see Figure 1) for understanding inequities in health (Solar & Irwin, 2007, cited in Blakley, 2008).

**Figure 1. The Commission on Social Determinants of Health's framework of the social determinants of health and health inequities.**



The framework shows how social, cultural economic and political mechanisms give rise to a set of socioeconomic positions, whereby populations are stratified according to income, education, occupation, gender, race/ethnicity and other factors. The social determinants of health (material circumstances, access to social support, high-risk behaviours) stem from this underlying social stratification to threaten people's health and determine differences in exposure and vulnerability to health-compromising conditions, such as stress, poor nutrition and violence (Solar & Irwin, 2007, p.35). This means that different groups will have different experiences of material conditions, psychosocial support, and behavioural options, which make them more, or less vulnerable, to poor health. The impact is also evidenced in differences in the level of access to health-care services, including health promotion, disease prevention, and treatment of illness (CSDH, 2008; Solar & Irwin, 2007).

Gender inequality has been discussed as a major determinant of health and combined with other components of socioeconomic position (such as ethnicity, income, and education) has a significant effect on an individual's vulnerability to risk and health outcomes (Solar & Irwin, 2007; Moss, 2002). It has been shown to be responsible for making women more socially, culturally and biologically at higher risk of morbidity and mortality and compromises women's ability to receive adequate and responsive health care in most developing countries (Cohen, 1998; Meleis, 2005).

Moss (2002) proposes a multidimensional approach, explicitly for women's health, that reflects the complexity of women's history and lived experiences and draws attention to the effect of gender equality and socioeconomic inequity in the patterning of health. Unlike the CSDH, Moss does not directly consider casual pathways. However she provides a comprehensive framework which outlines a host of interrelated factors that affect the way in which women's health is shaped. Moss draws our attention to five categories, which go beyond specific health outcomes and behaviours, to show the affect of gender inequality and socioeconomic position on health. Moss proposes that we examine:

- The geopolitical environment, such as policy (i.e. structural adjustment), social services and legal rights
- Culture, norms and sanctions which give rise to discrimination based on gender, ethnicity, marital and age.
- Women's roles in reproduction and production that are designed at the household level and relate to the distribution of resources.
- Health related mediators such as social networks and psychosocial factors
- Health outcomes, in terms of their link with women's health at different points in the lifespan and across cohorts.

Vlassoff and Bonilla (1994) demand greater examination of the social, economic and cultural determinants leading to sex differences in exposure to disease, intensity of infection, extent of care, access to and utilization of services and the impact of illness on production and domestic work, social activities and personal life. They claim the social and economic aspects of tropical disease have received limited attention and what research exists has been driven by epidemiological research priorities such as prevalence and risk factors (Vlasoff & Bonilla, 1994, p.38). Fikree and Pasha (2004) expose gender differences as the main factor contributing to inequalities and threats to women's health throughout the lifecycle in South Asia. Women face unequal opportunities in education and access to the labour force, meet inherent barriers through male- child preference practices, and are constrained by their legal and social status. In many parts of the developing world especially in patrilineal societies, a girl-child has a 30 to 50% higher chance of dying than a boy and adolescence is marked by ill-health due to early marriage, pregnancy and violence by male relatives. Violence against women is often condoned by laws which permit the abuse and

battery of women under the pretext of male ownership over women, and religious or family sanctuary (Meleis, 2005).

The nature and volume of women's work is also a source of risk for women and careful consideration is required of its effect on health and illness indices (Avotri and Walters, 1999; Meleis, 2005). Women in many developing countries work an arduous and long day, combining labour-intensive customary agricultural activities with the care of the family. This type of informal, unpaid work is excluded from market-driven analyses, despite 60 to 70% of production in developing countries being done by women (Meleis & Lindgren, 2002). The persistent devaluation of women's work compared with the value assigned to "masculine" activities (WHO, 2003) means that women lack control over material and emotional resources needed to sustain good health. Women are also increasing part of the formal labour sector, typified by low-paying jobs, with high risks of physical injury and adequate protection from labour laws (Schoenfed & Juarbe, 2005; Wadsworth & Butterworth, 2006).

Policies and strategies that apply a narrow definition to women's health may prove ineffective because they do not take account of key factors outlined above, such as social disadvantage, vulnerability and discrimination, which are intrinsic to the poverty-ill health cycle (Braveman & Gruskin, 2003). In response, Meleis (2005) and Braveman & Gruskin (2003) propose a human rights, empowerment and social justice approach to health. Discussed in greater detail in Chapters 5 and 8, this will ensure due consideration in policy and practice of the links between human rights, health and social conditions and will also draw attention to government accountability and responsibility as duty bearers for the health of a population. Chapter 5 specifically examines women's barriers to achieving the right to health. It suggests that eliminating systematic health disparities requires an empowerment approach to health to correct the underlying conditions necessary for health, such as education, living standards and equality, as well as mitigate their health-damaging effects.

### **1.2.3 Health protecting resources and the relationship to psychosocial health**

An essential feature of the determinants of ill-health relates to women's access to and control over interrelated resources which are necessary to protect health. These resources, which include standard of living, knowledge and power, culture and history, social institutions (such as social support and social networks), political structures, economic systems and technology (Anderson et al., 2003; Cohen, 1998, p.189; Link & Phelan, 1995), can be used to avoid risk or to minimize the consequences of ill-health once it occurs. It is now understood that people who have more resources in terms of knowledge, money, power and prestige and social connections are better able to avoid risk and to adopt protective strategies (Solar & Irwin, 2007; Wilkinson, 1996).

In industrialized nations, including Great Britain, Scandinavia, Russia and North America, there is an increasing recognition of the ways in which people's social and psychological circumstances seriously impact and damage long term health. Material, behavioural and psychosocial pathways have been shown to have a powerful influence on health (WHO, 2003; Denton, Prus & Walters, 2004) accounting for the health differences within a society (Seigrist & Marmot, 2006; WHO, 2003; Wilkinson, 1996) and the poor health of countries compared to the more favoured countries of the West (Brunner & Marmot, 2006). Although social and material deprivation runs to the top to bottom of society, with reduced standards of health at every step down the hierarchy, those at the bottom of the social hierarchy (as defined by education, income, employment status, ethnicity) suffer the greatest social, psychological and emotional deprivation and this may have a greater impact on their health than the more direct effects of deprivation (Wilkinson, 1996). Psychosocial pathways of subjective experience and emotions reflect the conditions of daily life and produce acute and chronic stress, which affect very powerful influences on physical health – on both morbidity and mortality (Marmot, 2006; Wilkinson, 1996). Much can be extrapolated from these studies in order to understand how the multiple demands that many women in the developing world face on a daily basis impact on their physical and psychological health.

Women's psychosocial health problems and forms of distress, such as anxiety and stress, are beginning to receive closer examination in the international literature for

their links to the social and material circumstances of women's lives and women's ability to cope (see Chapter 6 for a more detailed discussion). Meleis and Lindgren (2007) reflect on the seriousness of the psychosocial or emotional costs of worry, the overload or sense of oppression associated with women's labour and management of the multiple responsibilities of caring.

Financial insecurity, gendered roles and heavy workloads have been shown by Avotri and Walters (1999) to impinge on Ghanaian women's physical and psychological health but women have no power to shape their circumstances or to effect structural change. Low-income Egyptian women experience significant multiple-role stress in their attempt to balance work outside the home with domestic, social and marital obligations (Hattar-Pollara, Meleis & Nagib, 2003). Mid-life rural Canadian women similarly regard the stress in their lives to be associated with their multiple roles and being too busy, and they develop strategies (flexibility and adaptation, socialization and participation in social activities, relaxed environment) in response to maintain the relationship between body, mind and spirit (Thurston & Meadows, 2004).

Shultz and Lempert (2004) discuss the link between women's poor psychosocial health and race-based residential segregation and associated economic and social divestment that has eroded women's ability to build social networks. It is also well known that as health-enhancing resources, social interactions and sustained ties with families, friends, churches and communities give women the strength and support necessary to cope with the hopelessness and despair of overwhelming life circumstances, including racial discrimination, economic constraints and isolation (Leipert & Reutter, 2005; Schultz & Lempert, 2004; Utsey, Ponterotto, Reynolds & Cancelli, 2000).

Cattell (2001) discusses the significance of social networks for meeting different needs, whether to provide people with support when things go wrong or to give people the opportunity to talk about their problems. Chapter 7 provides further examination of how the socioeconomic conditions of women's lives impact on women and their psychosocial health, such as their level of stress, sense of control over life and self-esteem and how women survive and cope with these stressors. It is

again reiterated that those who are best positioned with regard to important social and economic resources will be less afflicted by disease and psychological problems (Link and Phelan, 1995; Shaw, Dorling, and Smith 2006). Chapter 7 shows that family relationships and domestic and workload demands shape the nature of women's experience, their stress experience and how they tend to cope.

Kasle and colleagues (2002) describe key characteristics of resilient women as including being able to meet demands and adapt to change and also to have the independence, information and resources to make choices in their best interest. Leipert and Reutter (2005) note that women develop resilience by developing behavioural and psychological strategies to maintain and advance health in the face of vulnerabilities to health. Women develop courage, self-esteem, confidence and skills to cope with a context that contributes to their vulnerability. The nature and use of these strategies is influenced by socio-cultural and personal factors and the degree of vulnerability women experience. Waller (2001; cited in Earnest & Faulkner, 2009) suggests factors that promote or constrain the development of resilience can be biological, psychological, socio-cultural, spiritual and environmental and related to the individual, family, community or wider social, economic, cultural and political context. The complex interplay between individual factors, such as personal resources and spirituality, and the wider social system, for example the availability of social support, social services and economic opportunities, must be examined for the influence on resilience.

Women demonstrate extraordinary inherent resilience and it is suggested that prolonged exposure to adversity might desensitize women to the impact of marginalization and disadvantage and contribute to greater emotional adaptation (Edge & Rogers, 2005). However many of the structural threats to health and a resilient individual, such as gender relations, economic constraints, geographical isolation and local and national political apathy are beyond the capacity of women to change. As such, resilience and problem-solving in the face of consistently high levels of stress could have an impact on mental health in the long-term, with women powerless to effect real change in their lives or able to confide in others about their problems to conceal their psychological distress.

#### **1.2.4 Inequalities, human rights and women's health in Papua New Guinea**

Women's health in Papua New Guinea is defined by health professionals, scientists and policy makers who prioritize only one dimension of women's lives, such as their biological, and/or maternal roles. The result is the absence of coherent research that reflects the complexities of women's histories, cultural contexts and lived experiences and provides a holistic view of women's health (Meleis & Im, 2002).

Nearly two decades ago, Gillet (1990) provided a timely and still very relevant review of women's health issues in PNG. Although it had a strong reproductive health focus, women's health was set within its wider social and cultural context and the implications for research, policy and practice were discussed. Since Gillet's review, there has been limited systematic research examining how the social and economic inequalities that women experience in their daily lives impact on health and the implications for access to health protecting resources. An exception is the study by Macintyre (n.d) who found that women on Lihir Island have poor health because their health is not valued in itself and because the value of women is lower than that of men. As has been documented in South Asia (Buckshee, 1997; Defo, 1997) Macintyre makes the association between women who have a lower social standing, a result of leaving a husband or being an unmarried mother, and poor health indices. The emphasis of her study was on the implications specifically for women's health and women's status, although it was not explicitly orientated towards an applied perspective.

Two major studies on human rights in Papua New Guinea have been carried out by international human rights organisations Human Rights Watch (2005) and Amnesty International (2006). Their conclusions are of widespread systematic patterns of abuse perpetuated by police and endemic violence against women and children by male relatives and both known and unknown perpetrators. The threat of gender-based violence, particularly sexual violence, impacts on women's ability to move freely in the community, to use public transport, to access health and education services, and to travel to market or to the workplace (Amnesty International, 2006). Widespread violence and abuse, including rape, together with a weak health system, high levels of poverty and socioeconomic inequity contribute to poor women's health indicators. The studies of Human Rights Watch and Amnesty International build on the only



national survey of domestic violence conducted in Papua New Guinea by Toft (1986), which estimated that over 60% of women are physically abused by their intimate partner, and Bradley's (1994) examination of the links between domestic violence and development.

There has also been a lack of studies in Papua New Guinea that put rural women's experiences of health throughout the lifespan at the centre of health research. There has been a tendency for researchers to focus on physical or behavioural aspects of health, with an emphasis on risk factors, such as the impact of women's reproductive and productive role on nutrition (Groos & Garner, 1998). Women's health is also targeted and confined by researchers as a reproductive health issue (Kowalcek, Rotte, Banz & Diedrich, 2005; Passey, Mgone, Lupiwa, Seve, Tiwara et al., 1998) and is examined from the perspective of knowledge, attitudes and practice of STI transmission (Lupiwa, Seve, Horton & Passey, 1996) or access to health care (Garner, Lai & Baea, 1994).

Finally, notwithstanding the socio-cultural and anthropological studies, of which there is limited space to review here, that provide good academic understandings of health and illness, but are less applied in orientation (Ayers Counts & Counts, 2004; Counts 1980; Frankel & Lewis, 1989; Mallet, 2003; Wardlow, 2006; Winkvist, 1996), psychosocial and socioeconomic studies of women's health are uncommon, particularly those with a gender focus. Mallet (2003) examined local notions of the gendered person as expressed through local knowledge and practices relating to health and illness, particularly women's health associated with pregnancy and birth. Although she takes a single focused approach to women's health, Mallet aims to represent the experiences of women as lived by women themselves.

The growing dialogue and debate around HIV transmission dynamics in PNG has raised much needed awareness about the impact of social conditions on health and anthropological investigations have shown that sexual health and female risk-taking behaviours are strongly affected by women's social, cultural and economic situation, and specifically gender norms and relationships (Hammar, 2008; Wardlow, 2002; 2006). High rates of gender-based violence have been shown to be damaging for women's health and in combination with economic and social marginalization,

increases women's vulnerability to HIV (Hermkens, 2008; Lepani, 2008). Gender differences, which result in low status, powerlessness and oppression, have also been cited as the basis of female suicide in Papua New Guinea (Ayers Counts & Counts, 2004; Booth 1999; Counts, 1980)

Accounting for the gaps in the socio-cultural literature on women's health in Papua New Guinea, the papers contained in this thesis aim to contribute insights into firstly, the impact of the material and social conditions of women's lives on women's health, with the application of a psychosocial and rights-based framework, and secondly, the problem of inadequate health care for women due to women's health being prioritized as a reproductive health problem. The three main areas of concern are:

- The universal issues that cut across age groups as well as the specific self-identified health needs of women as they move through the life span, and the implication for obtaining adequate health care
- Social inequities in health and the role of gender as an illustration of health inequalities and the relevance for women's rights and women's health outcomes
- The relationship between the material circumstances of women's lives, psychosocial health and the implications for women's ability to cope.

The study site of the Wosera is optimal for investigating these topics. First, women throughout the life span have access to health care, albeit limited, but the available services specifically target married and childbearing women. Second, the study site is situated in a poor rural area where people have limited access to income, resources, services and opportunities. And third, the status of women is lower than that of men, evidenced in the heavy workload burden, lack of women in decision-making positions and violence against women.

### **1.3 Objectives of the study**

Based on a review of the literature and research gap analysis, four objectives were developed on which this thesis is based. The four objectives are outlined below and Chapter 2 provides a more detailed overview of the study aims and objectives. In

addition, Table 1 in point 1.9 below outlines the structure of the five findings chapters according to study objectives.

1. To examine women's perceptions of health and health-related experiences at different points in the lifespan
2. To identify barriers to women achieving good health using a rights-based and women-centred perspective
3. To investigate women's coping with the challenges associated with the material conditions of their lives and the maintenance of health
4. To examine women's health using a gender analytic framework in order to identify priority areas for public service intervention

#### **1.4 Study setting**

The study described in this thesis was undertaken in Patigo village, Wosera/Gawi<sup>4</sup> district in the East Sepik Province of Papua New Guinea around 100 km from the coast (see Figures 2 and 3).

**Figure 2.** The East Sepik Province (PNG Tourism, 2010).



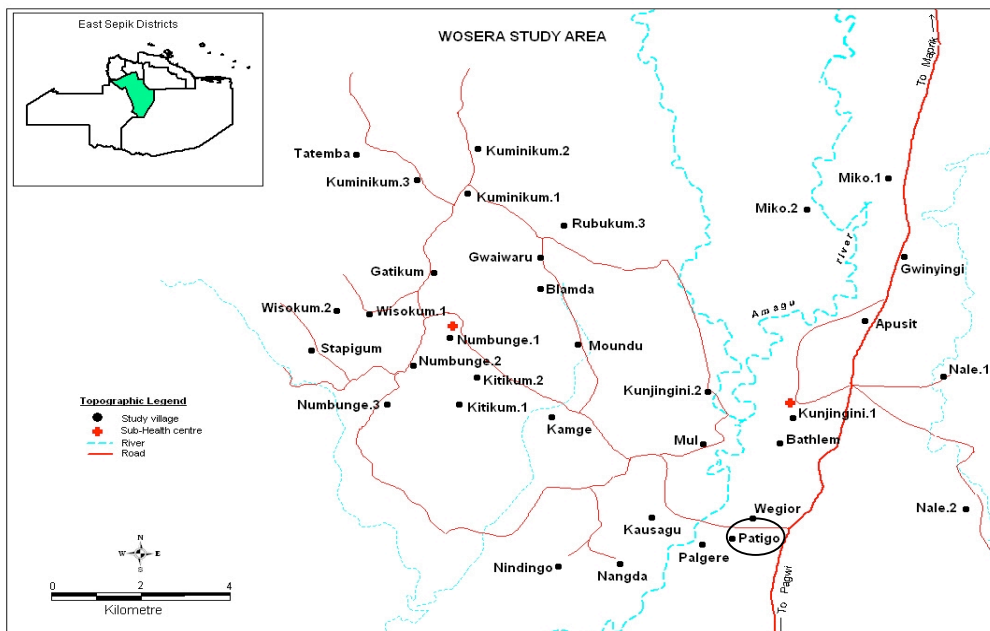
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<sup>4</sup> Hereby called the Wosera.

The Wosera is part of the Abelam ethnolinguistic group, which has a population of over 100,000 people and is located between the Prince Alexander Ranges and the sparsely settled Sepik grasslands to the South. The Abelam speak dialects of a language of the *Ndu* family and based on dialectical and minor physiographic differences, four Abelam regions can be defined: the North Abelam, the East Abelam, the Wosera and the Sepik Plains (Lea, 1965). Yams form the basis of people's diet supplemented by taro, bananas, sweet potato, many types of pulses and leafy vegetables, corn, peanuts, pawpaw and pineapple, and store bought items such as rice, tin fish and corned beef. Sago is also a seasonally important staple, having a place in both the social and subsistence practices of the Abelam (Tuzin, 1992).

Although the Wosera district is the second least populated district in the Province (National Statistics Office, 2002), with a total population of 49,000, and a population density as high as 400 persons per square mile, it is the most densely populated area of mainland Papua New Guinea (Lea, 1965; Winkvist, 1996). These densities are very high for an economy based largely on subsistence agriculture, and although mediated by out-migration, there has long been concern at the sustainability of subsistence systems in the long term under increasing cash cropping and high population growth rate (Curry 1997; 2005 Curry & Koczberski, 1999; Forge, 1990; Lea, 1965), which is currently at least 3.5% in the East Sepik Province.

**Figure 3.** The study site (circled) in the Wosera District, East Sepik Province (Courtesy of the PNGIMR)



The rates of out-migration in the Wosera are relatively high, with migration patterns generally being short-term circulation by males to find work and/or visit kin (Curry & Koczberski, 1999). This is evidenced by the sex ratio of 95.1 in 2000 (National Statistics Office, 2002). There is also evidence of growth in the number of families leaving the Wosera permanently, with 28% of households in one Wosera village living elsewhere in 1996. Major disputes caused by increasing resource pressure have been identified as a significant determinant of family out migration (Curry, 1997; Curry & Koczberski, 1998; 1999).

Abelam clans are patrilineal kin groups and every man and woman belongs to the clan in which he or she was born (Huber-Greub, 1990). Within a village several clans are represented. A woman is a metaphorical “flying fox,” that is, unlike a man or “coconut palm” she is not bound to a socially defined point or attached to land with roots. A woman can marry anywhere, into other clans and villages (Huber-Greub, 1990). The complementary gender roles and responsibilities in Abelam society has somewhat altered since earlier ethnographic descriptions (Huber-Greub, 1990; Kaberry, 1941; Scaglione, 1986). In the Wosera women conduct most of the daily subsistence and domestic duties which is highly gender specific and are involved in income generating activities such as the selling of betel nut, food crops and cooked food. Incentives to acquire cash have grown due to an increasing reliance on store products and “quality” food, which consists largely of canned or smoked fish, corned beef and rice.

The rising costs of education have also meant women have become more involved in commodity production and income generation to raise funds for their children’s school fees. In 2004 school fees ranged from K100 (AUD\$64) for primary school to K1,200 (AUD\$774) for day students in grade eleven and twelve (Human Rights Watch, 2005). This is a struggle for most Papua New Guinean’s given the average income in 2006 was AUD\$2 per day (UNICEF, 2008)<sup>5</sup> and the high costs are a contributing factor to the low levels of access to education in the country. Only 68 % of primary school entrants completed grade five in the period 2000 to 2005 (UNICEF, 2008).

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<sup>5</sup> The Gross National Income in 2006 was US\$770.

Men are traditionally responsible for heavier subsistence tasks such as the cutting and clearing of new gardens, the planting of yams, cutting sago palms and building houses and latrines. However, men's duties have become selective, sporadic and seasonal and less related to the immediate needs of the family. The traditional tasks of men have been more influenced by change than those of women. For example, the tending of ceremonial yams and cultural activities associated with the *haus tambaran* (ceremonial houses), considered significant to male prestige and with that of the clan, have lapsed in the Wosera. This is in contrast to their Northern Abelam neighbours. In villages around Maprik (such as Apangai and Numbunge) there were many ceremonial yam growers, and each village contained a large and well decorated *haus tambaran*. Many ceremonies and practices associated with the yam cult are still conducted and believed to be essential for food production, the maintenance of life and the political economy (Forge, 1990; Huber-Greub, 1990; Kaberry, 1941; Lea, 1965). In addition, a man whose father would have been mainly engaged in territorial defence now has more time for other activities such as cash cropping and recreational pastimes. Amongst the Wosera there is now a general focus on obtaining cash due to pressures from stores and a desire for modern material goods, a liking for beer and cigarettes and aspirations to leave the village to experience the wider world (Lea, Joel, & Curry, 1988). A woman however, remains the provider of subsistence crops and domestic necessities, a role that is becoming more arduous. Women are increasingly taking on male tasks since their husbands have more options concerning their own activities (Toft, 1986). Formerly a male activity, the cutting down of the sago palm, a very difficult and physically challenging undertaking, is now predominantly a female task in the Wosera.

Patigo village has a population of around 700 people and is situated near the Sepik highway, which links the district to Wewak, the Provincial capital. Relative to other villages in the district, people have good access to public motor vehicles (PMV) for Wewak (120km, K20) and Maprik (20km, K5), a small administrative and commercial centre for surrounding Wosera, Dreikir and Ambunti districts. Subsistence farming is the major economic activity although an increasing number of villagers derive cash income from cash crops (vegetables, betel nut, peanuts, cocoa and vanilla for the Maprik and Wewak markets) and local food markets. The ability

to acquire a cash income from tree crops (cocoa and vanilla), however, requires access to land. Due to the patrilineal descent system, women cannot obtain long-term access land rights and are disadvantaged as a result (Lea, et al., 1988). At the time of this study there were several small enterprises in Patigo, which included two tradestores, two PMVs, a small timber business, a chicken project and a very informal second-hand clothes market.

Patigo was chosen for its relative accessibility to services and resources compared with other parts of the Wosera population, although an outside observer would notice very little difference between Patigo and other villages in the Wosera, with relatively few permanent timber houses and iron-corrugated roofs. It is typical of Wosera villages with a heavy reliance on subsistence production for household consumption, high infant mortality and morbidity rates, limited cash earning opportunities and low per capita incomes (Curry, 1999; 2005; Curry & Koczberski, 1999).

#### **1.4.1 Health in the study area**

The Wosera district is one of the lesser developed areas of Papua New Guinea. Its name, a corruption of the colonial patrol-officers description “worse area” conveys the poor levels of health and nutrition experienced by the population (Reeder and Taime, 2003). Indices of health are poor in the Wosera with the National Department of Health (2000) recording perinatal conditions as the second leading cause of death (34.6/100,000), after pneumonia (42.8/100,100). The prevalence of malnutrition is common in children under 10 years old and 24% of recorded births have a birth weight of less than 2.5kg (National Department of Health, 2005). In 2004 antenatal coverage in the Wosera was recorded at only 48%, below the national average of 58% (WHO/WPRO, 2008). Only 12% of births had a skilled attendant at delivery (National Department of Health, 2005). The most recent census data shows that of the rural citizen population in the East Sepik only 43% of women were literate<sup>6</sup>, slightly lower than the national rate of 46%. This was however a significant increase from 29% in 1990 (National Statistics Office, 2002). Only 6% of the female rural population were recorded in 2000 as having completed an education level of Grade 10 or above.

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<sup>6</sup> The percentage of the population aged 10 years and over

Health services in the area are provided through one government health centre (Wombisa) and Kunjingini health sub centre, the primary health care facility run in association with the local Catholic mission and less than an hours walk. Kunjingini offers primary health services at their outpatient department, a 12 bed inpatient ward and delivery room. The Maternal and Child Health (MCH) clinic conducts mobile outreach throughout the centre's catchment area (population of 8000) and antenatal clinic every Friday. Three local women, a *marasin meri* (medicine woman), Village Birth Attendant (VBA), and a family planning educator, were trained as health volunteers by the Save the Children Fund (PNG) "Women's and Children's Health Project" and are active in Patigo. Together they provide basic family and sexual health education, basic treatment for common and minor ailments, family planning support and assistance for pregnant women with village births. The local referral centre is Maprik Hospital, a 110-bed government hospital serving 150,000 people living in the surrounding districts.

## **1.5 Professional context of the researcher and interest in PNG**

The basis for my interest in women's health in Papua New Guinea can be found in an education that focused on the contemporary Pacific and which highlighted the disparities facing women both in the Pacific Region and in other developing countries. It is also a result of working with and learning from women in various parts of Papua New Guinea for the past seven years.

I grew up in New Zealand which enabled me to gain a good understanding of Maori history and the social, economic and cultural challenges facing Maori in the contemporary context. New Zealand is made up of large populations of Pacific Island people from Fiji, Tonga, Cook Islands, Niue to name a few, and as such I developed a strong awareness of the diverse cultures of the Pacific and New Zealand's position as a larger Pacific Island nation. I decided to deepen my knowledge of Pacific cultures by studying Anthropology at the University of Waikato, a university well known in New Zealand for its strong Pacific focus. As part of the undergraduate program we were required to critically examine the social, cultural, economic and



political complexities facing Melanesian and Polynesian peoples in the contemporary context and that affecting populations in other developing country contexts.

My Masters thesis in Anthropology focused on the role of Bougainvillean women in the development process at the end of the 12 year civil conflict. I lived in a small rural community in South Bougainville for three months in 2000-2001. This gave me a very good opportunity to experience first hand the complex issues facing women on Bougainville in a post-conflict context associated with access to services, freedom of movement, drugs and alcohol, trauma, violence, reconciliation and rehabilitation and the participation of men and women, combatant and non-combatant, in the development and peace process.

I moved to Papua New Guinea in 2002 where I worked as a Senior Scientific Officer for the Papua New Guinea Institute of Medical Research (PNGIMR), a position I held for over four years. There were several main areas of focus of research during this period including women's and reproductive health, socio-cultural meanings of health and illness, prevention and treatment preferences for disease and the evaluation of child health campaigns. As a Senior Scientific Officer with the PNGIMR, I was able to gain a much deeper understanding of the issues facing women, and more specifically, the multiple disadvantages and constraints affecting women in Papua New Guinea. I observed the context surrounding the poor health status of the population and saw the impact of economic disadvantage, violence and other social, cultural and structural factors in the lives of women and children in urban and rural areas. Of particular concern was the high morbidity and mortality of women in PNG. Most deaths were from preventable causes.

I have developed particular strengths and understandings through my experiences of working in Papua New Guinea with the PNGIMR and more recently with Oxfam International PNG. I understand and respect the need for local processes, approaches and views in the design, implementation of research, programs and other initiatives. Top-down measures are often a stop gap, reactive measure that do little to address the underlying causes of inequalities, violence and instability in PNG. I have learned perseverance, patience and flexibility are key factors required for living and working in difficult socio-cultural circumstances. My strength is that I try to prioritize process

over outcomes. Through capacity building, with local staff and local organisations, and a process that involves participation, inclusiveness, empowerment and mutual respect, I have learned that the conditions can be created for positive and sustainable outcomes.

A small qualitative study on women's health in pregnancy that I conducted with the PNGIMR in the Wosera, East Sepik Province in 2003 brought the social determinants of women's health to my direct attention. Although pregnancy is an obligatory and important rite of passage in women's lives, it became very clear in discussions with women that their health in pregnancy was only part small part of a very complex struggle to be healthy. My questions that focused on women's physical health in pregnancy and their methods of maintaining their own health and that of the unborn child were embedded in descriptions of the struggles of daily life. Women discussed their relationships, the economic constraints and helplessness that constrained their health. Women's health in pregnancy was not isolated from the relationships within which it occurred and being pregnant was only one of many constant and daily burdens that affected health throughout their lives. This realization underpinned the development of the current study.

This study was designed to examine the health of women in a rural context of Papua New Guinea and is situated within the circumstances of women's lives. I used a multi-method approach to investigate women's own concepts of health, the barriers to health and the opportunities to enhance the right to health for women at critical stages throughout the life span, especially in the areas of social and economic development, resilience and coping and access to appropriate and equitable services.

In all I have lived in Papua New Guinea for 7 years. I spent 4 years working in the Wosera and of that I lived for 2 years in Maprik, the site of the PNGIMR East Sepik office. The research period was for a select period of time and I spent time in the field prior to and following the research.

## **1.6 Conceptual and theoretical framework**

During my time as a social researcher working for the PNGIMR I was well aware of discussion around the social determinants of health and that persistent disparities in health are among the most pressing public health concerns of our time. This was reinforced by my understanding of the Alma Ata Declaration and when applied to women's health it meant that women's health issues surpassed reproductive and childbearing needs. According to Weisman (1997), women's health is a product of cultural, social and psychological factors as well as biology and is saturated with gender-based inequalities. Although biological differences between men and women do exist, socially constructed gender differences and gender-based social inequalities are fundamental variables affecting health. Women's health concerns the totality of women's experiences throughout the life span, with the implication that overall health includes, but is not defined by, reproductive health.

Health is also more than the absence of disease and requires health maintaining and health promoting strategies by both the individual and society. This study documents the diverse and complex nature of women's health in Papua New Guinea and examines social, cultural and economic factors which influence health throughout the life span. Women learn resilience and coping strategies to deal with vulnerabilities to health and show strength of character and confidence in the face of adversity. Women's life experiences and psychosocial health needs are conceptualised in this study as the basis for health research and for the development of relevant health policy and services to address the needs of women.

The position adopted by Freedman (1999) is that women's health is not simply a biological problem that can be addressed solely through improved medical technologies, but is a product of the same forces that structure a woman's relationship to the physical and social world around her and which can be addressed through social policies, programs and activist movements. This stance formed the basis to the application of a human rights framework in this study, in which I positioned women and their experiences with fear, abuse, oppression and discrimination at the centre of the research and prioritized women's empowerment for improved health (Weisman, 2002). This also meant the discrimination and gender

inequalities that underlie women's health were examined in a sensitive and appropriate manner (for example conducting interviews early in the morning to take account of workload burden, open questioning, use of narratives and storytelling) and that encouraged the meaningful participation of women (creating a relaxed environment, building rapport, free to discuss issues outside of study focus).

The choice of research methodologies and the study's non-experimental, interpretative and qualitative design was appropriate to the social context and sensitive to the time and communication needs of participants. Qualitative methods were appropriate for capturing and understanding individual and community definitions, descriptions and meanings. My objective was to understand life in ways that considered the perspectives and experiences of people who lived it. Throughout the study I used rapid ethnographic assessment, a modification of traditional ethnography which accommodated a combination of qualitative methods and a shortened time line which can range from 3 days and 6 weeks (Dageid & Duckert, 2008; Rice & Ezzy, 1999). To ensure the balance between speed and trustworthiness (McNall & Foster-Fishman, 2007), the challenge of shortened time period can be overcome with well-designed short term methods, by building on existing knowledge in communities and by using strategies for the rapid development of rapport, including working with local staff and collaboration with local initiatives (Singer & Baer, 2007).

Rapid techniques can bridge the gap between time-intensive traditional ethnographic methods and health policy and programming. It has been used to provide social and cultural underpinnings to health development programs and interventions within a specific geographical area, such as sites within Peru and Nigeria (Bentley, Pelto, Straus, Schuman, Adegbola, De La Pena et al., 1988) and Mexico (Guerro, Morrow, Calva, Ortega-Gallegos, Weller, Ruiz-Palacios & Morrow, 1999), and for monitoring the effectiveness of programs, projects and systems (McNall & Foster-Fishman, 2007). The value of this approach has contributed to the development of other accelerated assessment models, including rapid rural appraisal (Singer & Baer, 2007). Rapid ethnographic assessment supported a flexible approach. It allowed for the inclusion of new methodologies or sub-groups of the population for different

perspectives if the research required it. This study enjoyed a longer timeframe than conventional rapid assessments and was undertaken over a four month period.

I developed and applied multiple data collection methods to facilitate a more detailed explanation of women's health experiences than a single technique could provide. This included focus group discussions, in-depth interviews, participatory diagramming, photo narratives and ranking exercises. By using different qualitative data collection techniques I was able to highlight a variety of perspectives, draw conclusions from a synthesis of the results and validate the data through triangulation. The choice and use of methods were rooted in and interacted with other components of the research design – the rationale, research questions, validity and conceptual context (Sobo & Munck, 1998).

In the context of ethnographic studies, the researcher has little or no control over variables. As such, the purpose of this research design was not to examine linkages between variables across sites but to focus on the descriptions and linkages between events, experiences and activities within a particular site. In semi-literate societies such as Papua New Guinea, narratives and storytelling are an important social and cultural tool and these techniques were used in this study to elicit descriptions and stories from participants based on their experiences and real life situations. I used storytelling as part of interviews and group discussions to obtain information from the participant's perspectives about episodes and issues in their lives from beginning to end. By doing so I hoped to take into account Schensul, Schensul and LeCompte's (1999) principles for the management of interviewees' narratives which include, maintaining the flow of the interviewee's story, developing and maintaining a positive researcher-respondent relationship and avoiding interview bias.

Thematic analysis, an approach similar to grounded theory (Pope, Ziebland & Mays, 2006; Weerasinghe & Mitchell, 2007) an essential element of this research, and was based on the interpretation, identification and development of concepts, categories and themes while the research was being conducted. Thematic analysis of the data allowed for the development of themes which could shift or become transformed through the exploration of new meanings and explanations. It is through the themes that emerged from the iterative process of analysis that I propose recommendations

throughout this thesis to address the challenge of providing a more equitable approach to women's health in Papua New Guinea.

### **1.7 Limitations of the research**

Although I had lived in Papua New Guinea for over three years at the time of this research, I was still considered an outsider, with a "Western perspective," which may have influenced people's decision to participate (both positively and negatively) and affected the responses to questions. Rumours had spread that I was interested in sexual health, with the view to promote family planning. This drew male resistance to the study and women were hesitant to participate and "give up their secrets." Although this misunderstanding was dealt with and the study was accepted by men and women alike, it still may have affected the willingness of women to participate.

I accept that I had some bearing (age, class and ethnic differences) on the collection and analysis of the data and I was a co-participant in the creation of knowledge. This study presented many women with the opportunity to talk about their own issues, on their own terms and in a confidential environment. However some women were shy, guarded and hesitant to open up. I was well aware of some participants' initial nervousness and apprehension by their body language and style of communication. It was also possible that some women preferred to say what they thought I wanted to hear, or withheld specific details of their story, not fully trusting that I wouldn't share the information with others.

Due to the public context of the village setting, interviews or focus group discussions could not be consistently held in private. On several occasions an inquisitive community member would take their time to walk past or stop and listen to the discussion taking place. Although new and different locations were sought to suit the needs of individual respondents, it was almost impossible to conduct an interview without another person interrupting proceedings. Noise levels were occasionally too high and affected recording (rooster crowing, children crying, school children playing, heavy rain) yet it was not always possible to change the interview setting.

To take into account women's workload obligations, group discussions were held on specific days chosen by the participants. On several occasions, participatory diagrams and focus group discussions exceeded two hours and some participants became unsettled and tired, losing concentration and interest in the discussion. Although the study time frame allowed some flexibility so that the discussion could have ended and resumed on another day, women's time and workload obligations did not.

The applied aspect of this research determines that recommendations be translated into appropriate, quality, affordable and accessible services and health care for women in rural areas of Papua New Guinea. Many of the recommendations made in this study have been developed from a bottom-up approach. They are based on discussions with women, health workers, teachers, local level government councilors and other community members at the local community level, and reflect the importance of understanding the community level at the policy level. Formal interviews were not conducted with the Wosera district, Provincial and policy level health officials. Although these discussions might have revealed further challenges, opportunities or suggestions from a higher policy level, and possibilities for engagement, the focus of this study was the women themselves, and their relationship to the health system.

## **1.8 Significance of the study**

In Papua New Guinea, as in many developing countries, women are an operationally important population subgroup with respect to health and health outcomes. This is because, comparative to men, women experience different health risks and constraints and have different access to health protecting resources. The following chapters enhance our understanding of the social, cultural and economic factors that affect women's health, and provide deeper insight into the ways in which women manage the multiple role demands and stressors in their daily lives.

It has been ascertained that maternal mortality in Papua New Guinea is unacceptably high, related to poor physical and reproductive health and limited access to essential health care (National Department of Health, 2000). Preventive and curative services

are recommended in response. This research took a step back. It provides an addition to and broadens the biomedical and reproductive health framework devised in public health policy and practice to provide a counter to maternal mortality in Papua New Guinea. The research has yielded in-depth knowledge on the social and structural determinants of women's health that can be used to direct the design and implementation of appropriate interventions.

Bannister and Schreiber (2001) have challenged epidemiology for its disciplinary boundaries in what it can reveal about women's health. Wyn and Solis (2001) argues, too, that we have limited understanding of the diversity of women's social and cultural experiences that affect health throughout the life span. This neglects the opportunity to understand and provide appropriate support to women at critical transition points in the life cycle when support may be required. Therefore qualitative research methods that explore the health-related understandings and experiences highlighted by women at different stages of the lifecycle would more effectively and appropriately assess the impact of these socio-cultural experiences on health.

In order to examine the barriers to women's health, and associated issues of gender roles and responsibilities and socio-cultural constraints, this study looked at the links between human rights, health and the social conditions of women's lives. Most studies that examine women's health in Papua New Guinea do not focus on human rights or explore the ways in which women's experiences with fear, abuse, oppression and discrimination affect health and their access to resources. The dynamics of women's access to health-protecting resources and strategies to maintain health in challenging circumstances have rarely been investigated outside of the field of reproduction and family planning. Even less attention has been paid to the psychosocial determinants of women's health, including the impact of isolation, low self-esteem and lack of social support on health. The nature of stress that rural women experience in managing the demands of their daily lives and the coping pattern they use to offset stress has also been largely ignored.

This study therefore provides an understanding of how the dynamics of health, social conditions and social relations are constructed in Papua New Guinea as well as the degree to which women's low status and multiple roles and responsibilities affect



their ability to maintain good health. Additionally, it provides useful insights that have relevance elsewhere in the Pacific and other developing countries.

## **1.9 Outline of the thesis**

In July 2008 when reflecting on the presentation of the findings chapters it was decided in mutual consultation with my supervisor, that each chapter for analysis would be written for publication. Although this is not a thesis by publication, each analysis chapter has been developed for publication. I am aware that this process takes time and at this stage with the thesis prepared for examination, one chapter (3) has been accepted for publication, Chapter 6 has been provisionally accepted and 3 are currently under review. Copies of published and in press articles (following the submission of the thesis) are included in Appendices I to IV.

The outline of this thesis is as follows:

**Chapter 1** provides a detailed introduction and explanatory overview to the study. It includes a literature review which outlines the broader context of the field of study, the theoretically underpinnings and the main contribution of the research to knowledge.

**Chapter 2** presents the study objectives and the fundamental methodological decisions and approaches for the present study. The qualitative design is discussed in depth and examined for its relevance to the study objectives. The study site, recruitment and sampling procedures are outlined and the measures taken to ensure quality and rigorous findings. Also included in this chapter are descriptions of the research methods, the data analysis process and ethical considerations.

Based on the objectives outlined in Chapter 2, one of the major interests was to investigate women's perceptions and experiences of health and the interplay between women's health and the social, material and economic circumstances of their lives. These issues are developed and explored in Chapter 3 to 7 which form the crux of the analysis. Chapters 3 to 7 have been developed as series of five papers for publication.

Each chapter reflects the focus of the study's four main objectives. The structure of the chapters and their relationship to the study objectives are outlined in Table 1.

**Table 1.** Structure of five findings chapters according to study objectives

<b><u>Objective</u></b>	<b><u>Chapter number</u></b>
1	3;4
2	5
3	6;7
4	3;4;5;6;7

Throughout the course of the five chapters the reader's attention is drawn to specific but interrelated themes which reflect the multidimensional nature of women's health perceptions and experiences. Combined, the chapters are complementary and each builds on the next to develop a solid argument and an integrated narrative.

Chapter 3 and 4 reflect the first objective. These two chapters present the findings of women's perceptions and health-related experiences throughout the lifespan.

**Chapter 3** examines the understandings and experiences of health of young women. Drawing on key issues highlighted in international studies the chapter outlines the ways in which young women prioritize their health and health-related experiences in response to the social context. The findings present a distinct contrast to the prevalent epidemiological approach to adolescent health in public health policy and practice in Papua New Guinea.

**Chapter 4** continues in a similar fashion and offers further explanation to support an alternative to the narrowly defined biomedical discourse on women's health in Papua New Guinea. Drawing on experiences from adult and older women this chapter shows that the health priorities of women are not separate from other aspects of life or independent of the social and economic context. This chapter provides evidence of the disconnect that exists between women's perceived needs and health policy development and implementation in Papua New Guinea.

**Chapter 5** shifts the emphasis to the second objective, namely the social and gendered inequalities that lie at the heart of women's health. To examine social inequalities in health, this chapter draws on a rights-based and socio-cultural approach to health and applies it to the experiences of women's health in Papua New Guinea.

Chapter 6 and 7 address the third objective, namely women's coping with the challenges associated with the material conditions of their lives and the maintenance of health.

**Chapter 6** draws attention to the psychosocial health problems of women and the links to the social, cultural and economic environment in which women live. This publication suggests that the emotional and physical forms of distress evidenced among women, such as worrying, thinking too much, anxiety or sleeplessness reflect the consequences of the challenges women encounter in their daily lives. Unequal gender relations, economic constraints and multiple role demands contributed to significant psychological strain and stress.

Women's psychosocial health is taken up in **Chapter 7** with the examination of the ways in which women access resources necessary to protect health. In view of the fact that women's stressors are deep-rooted and shaped by the socio-cultural context, so too are the interpersonal resources available to women and the coping strategies women use to deal with adversity and maintain health. The findings in Chapters 3 to 7 are discussed in relation to objective four, namely the identification of priority areas for public service intervention with specific reference to the gendered nature of women's health.

**Chapter 8** critically reflects on the most important findings, and suggests that a holistic, rights-based and applied approach to women's health is required to better understand the relationship between women's health, socioeconomic status and women's opportunities to access health-protecting resources. The chapter also discusses the significance of the findings for future research, health policy and interventions for women's health in PNG.

The chapters contained in this thesis present a shift in focus from biomedical understandings of women's health to understanding health as it perceived by women themselves. This thesis introduces a multidisciplinary model to women's health in Papua New Guinea. Women's health is considered from a socio-cultural perspective, informed by a human rights based framework and based on the real experiences of women's daily lives. This thesis draws on the narratives of rural women to explore the reciprocal relationship between gender, health, human rights and development in Papua New Guinea. As it is presented here - focusing on women's health related experiences on the one hand and the appropriateness of service delivery to women on the other hand - this thesis may serve as an example of what occurs in many rural Papua New Guinean settings today. In this sense, this thesis can be read as a contribution to a better understanding women's health in PNG and to the challenge of improving and implementing appropriate and equitable health care for women.

## CHAPTER TWO

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### METHODOLOGY

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#### **2.0 Introduction**

This chapter outlines the aim and objectives and the fundamental methodological decisions and approaches for the present study. A qualitative research design was thought relevant for meeting the study objectives and was considered well-suited to the social and cultural context. The study site, recruitment and sampling procedures will be discussed and the measures taken to ensure the quality of the findings and the validity and reliability of the data collection and analytical process will be outlined.

The methods of data gathering, which were designed to have the flexibility to respond to changes in the field while being grounded in the research design, will be outlined and discussed, both as to their relevance for this study and that of understanding women's health in Papua New Guinea. The methods of data collection include in-depth interviews, participatory diagrams, focus group discussions and photo narrative exercises.

The process of data analysis, which was inductive in its approach and continuous throughout data collection, will also be discussed. Finally, the ethical considerations which guided the present study, and include the process of informed consent, participant confidentiality and the risks and benefits of participation, will be examined

## **2.1 Aims and Objectives**

### **The aim of the study:**

The overarching aim of this study was to undertake an ethnographic assessment of women's health within the socio-historical context of PNG to firstly, identify if there are critical points in the lifespan for affecting positive change in the health status of women and secondly, to ascertain if the gap between the perceptions of service providers and the real needs of women can be bridged. To meet the main aim and to guide the study, four objectives and eleven sub-objectives were developed.

### **General objective 1**

To examine women's perceptions of health and health-related experiences at different points in the lifespan

#### *Specific sub-objectives*

- 1.1 To describe the health needs and health-related experiences of young, adult and older women
- 1.2 To discuss the prioritisation of women's health needs at different points of the life span and the determinants of these priorities over time
- 1.3 To examine opportunities for support to women at critical stages in the life cycle

### **General objective 2**

To identify barriers to women achieving good health using a rights-based and women-centred perspective

#### *Specific sub-objectives*

- 2.1 To discuss women's understandings and experiences of the determinants of health
- 2.2 To identify the social, cultural and economic conditions which underlie inequalities in health and the relationship with women's poor health status
- 2.3 To investigate the role of gender as a key determinant of women's health inequalities
- 2.4 To examine the link between women's health and human rights

### **General objective 3**

To investigate women's coping with the challenges associated with the material conditions of their lives and the maintenance of health

#### *Specific sub-objectives*

- 3.1 To explore the psychosocial health needs of women and the links between the material conditions of their lives
- 3.2 To examine women's access to and control over the resources necessary to protect health
- 3.3 To investigate the implications of social support for the maintenance of good health
- 3.4 To describe women's coping strategies for meeting the challenges associated with the maintenance of health

### **General objective 4**

To examine women's health using a gender analytic framework in order to identify priority areas for public service intervention

#### *Specific sub-objectives*

- 4.1 To identify the gaps in policy and programming priorities for women's health and women's perceptions of the core priorities for improvement in their health status
- 4.2 To inform policy of the current health status of women set within the broader context of human development
- 4.3 To study the implications of gender and human rights for improving the quality of existing programs that provide services to women

## **2.2 Research design**

The study used a non-experimental, interpretive qualitative case study design. This type of research design made it possible to describe the perceptions and health-related experiences of a particular group of women and was well suited to understanding the social contexts of people's lives. A distinctive feature of a case study design is multiple methods and qualitative sampling techniques for site and participant selection. The intent is to address specific questions and issues rather than to identify a sample that is statistically representative of a population (Keen, 2006).

Qualitative data was collected and used to refine or determine questions and to identify themes inductively for the interpretation of findings. The research team consisted of the researcher, a local research assistant familiar to many members of the community and a local field assistant from Patigo. Methodological decisions were made in collaboration with the research assistant, and the local field assistant provided additional direction and advice specific to the socio-cultural context. The extensive consideration given to the appropriateness of the research design contributed to the reliability and validity of the findings.

Rapid ethnographic assessment method was the qualitative method of choice. Rapid ethnographic assessment maximises the strengths of anthropological open-ended and labour intensive data gathering and is suited to a shortened timeline (Singer & Baer, 2007). Rapid ethnographic assessment evolved from the recognition that a combination of elicitation techniques such as key informant / in-depth interviews and focus group discussions, together with observation techniques, enable researchers to explore social issues in a focused way and to identify factors for culturally appropriate interventions (LeCompte & Schensul, 1999). It allows researchers to learn about what is happening to individuals and groups of people within a specific setting and gain meaningful contextual data by paying necessary attention social and economic factors, cultural practices and local ecological circumstances (Bentley et al., 1988). The strength of the research design was in the structure of the methodology which provided the flexibility to respond to new conditions, unforeseen problems, or the emergence of new themes as they arose during the research process.

### **2.3 Recruitment procedures**

Difficulties with infrastructure and accessing remote, rural communities means that census or population statistics are often unavailable. This study however was not designed to select a random number of cases but participants were selected on purpose. Non-probability sampling was the most appropriate sampling technique for the in-depth study of a small number of cases within a relatively small population. Participants were identified using snowball, volunteer and purposive sampling techniques. Concerns for representation were met by an awareness and analysis of the evolving information for its common or irregular themes. Due to the well



established position of PNGIMR in the community, the researcher was very familiar with the research site and had longstanding contacts in it. Identifying a local field assistant and gaining access to women was relatively unproblematic.

The Papua New Guinea Institute of Medical Research was established in 1968 as a Statutory Body of the Government of Papua New Guinea. The activities of the Institute are directed towards conducting research into the most pressing health problems of the people of Papua New Guinea and to develop translatable and practical measures to improve health. Major research programs focus on respiratory diseases, vector-borne and diarrhoeal diseases, sexual health and HIV/AIDS and women's health. Operational research is directed at health systems and the impediments to acceptable, accessible and quality healthcare. The PNGIMR has been conducting scientific research in the Wosera District for over 20 years. Institute staff are well regarded and have worked hard to build good relations with communities (Reeder & Taime, 2003). The PNGIMR provided the researcher with the infrastructural support necessary to conduct the study.

Women were recruited from Patigo, a village chosen for its past community participation and cooperation with the PNGIMR, good road access to the Catholic sub-health centre and a reasonably active women's and volunteer network. These were seen as relevant to the study aim as it would be valuable to understand some of the constraints to the access of formal health care despite a relatively supportive infrastructure. The research was conducted in only one area of Papua New Guinea, to provide a case study and detailed illustration of the health concerns of a specific group of rural women.

The research was piloted in neighbouring Wegior village with a small number of participants. This was useful for the development and refinement of research instruments and for the identification of initial themes that could be explored more deeply in Patigo village. Prior to conducting the research in Patigo, a community meeting was called by the researcher and her research assistant. PNGIMR community relations officers attended the meeting and there was good representation of community leaders and male and female members of Patigo village. The researcher, supported by her research assistant and the PNGIMR community

relations officers provided information in *tok pisin* (Melanesian Pidgin), the local lingua franca, about the project, including the aims and objectives, the significance of the research and the proposed methodology.

Time was allowed for comments and questions, which mostly centered on clarifying the focus of the research (such as if its purpose was to encourage women to use family planning without her husband's permission) and requests for health promotion activities related to sanitation and hygiene. To assuage some local concerns that the local field assistant had communicated to the researcher prior to the meeting, reassurance was also given that questions would not be focusing on sexual behaviour and relationships or "family secrets." At the end of the meeting, consent for the project was given collectively by village leaders and community members. This, together with the sampling techniques, ensured a culturally appropriate and non-invasive approach to the recruitment process.

## **2.4 Sample size**

Women aged 18 to 24 years (young women), 25 to 45 years (adult women) and over 45 years (older women) were identified and categorised in their specific age range from Patigo village. Although age was a means of distinguishing between groups, this was problematic when women were unsure of their age. Although date of birth was a valid form of categorisation, other social and cultural variables in PNG differentiate a young woman from an adult woman, such as workload, marital status or number of children. Where some participants were uncertain about their actual date of birth, it became necessary to rely on social relationships and groupings rather than actual age. Because self identification and social acceptance came to underpin the sample process, several young women under the age of 18 years participated in the research and two women who were over 45 years identified with the adult women age group. The differentiation between older women and adult women was much clearer, as older women not only appeared older physically but were socially classified as "old" (reduced activities and workload, greater reliance on others).

The study was carried out with 33 young women, 27 adult women and 10 older women. We conducted 31 in-depth interviews (10 young women, eleven adult

women and 10 older women), 4 focus group discussions (2 groups of adult women and 2 groups of young women), 4 photo narrative exercises (2 groups of young women and 2 groups of adult women ) and 4 problem identification and ranking exercises (2 groups of young women and 2 groups of adult women). In order to uncover different perspectives relevant to the study objectives 12 key community members participated in an in-depth interview. Participants included:

- 2 nursing officers
- 2 community health volunteers
- 1 village court magistrate
- 1 community police officer
- 2 high school teachers
- 2 primary school teachers
- 1 village pastor
- 1 local community leader.

A focus group was also held with six young men and eight adult men respectively. The sample size was more than enough to meet the methodological requirements and the researcher had sufficient contact with the population to reach saturation of identified themes.

All participants were given the opportunity to speak a language they felt most comfortable, which in most cases was *tok pisin* or their first language (*Ndu*). Participants who spoke their first language were mostly women over 45 years who had very little exposure to or past practice in speaking *tok pisin*. The researcher was also aware that some women might feel uncomfortable or unsure talking about issues which were sensitive or private and seldom openly discussed. However, as word spread about the research, the research team was repeatedly approached by participants asking for their chance to “tell their story.” An exclusion criterion applied to participants with a hearing or speech impairment which would inhibit communication between the research team and the participant. This specifically applied to a small number of older participants. Language constraints and debilitating physical conditions which restricted the mobility and motivation of older participants impeded the study team’s access to this group of women. This only served to reinforce the somewhat marginalized status of older women in the community.

## **2.5 Quality criteria, rigour and researcher reflexivity**

This study was conducted using a rigorous methodology and a sampling strategy applicable to the context of the research. Qualitative methods do not lend themselves to the same kinds of detachment that are assumed to be possible with positivist and clinical studies. However, less interventionist, quantitative techniques, (such as a structured questionnaire) do not eliminate bias (predetermined questions, style of questioning), but simply change its form (Schensul, Schensul & LeCompte, 1999).

The local research assistant, though from a neighbouring village, was aware of the differences between herself and the research participants (age, class, occupation, local language skills). Class differences for example were clearly pointed out during a focus group discussion, when our clothes (which were very appropriate to the setting) were seen as of better quality than the participants with a respondent commenting, “look at your clothes compared to ours! Ours are all ripped and faded.”

Through the process of interaction and exchange both the interviewer and the interviewee agreed the direction of the discussion, the extent of which a particular event or experience was recalled and the identification of issues to be avoided or pursued (Manderson, Mark & Woetz,, 2006, p.1330). The researcher recognized people’s interpretations and meanings can change according to time and setting. However, understandings of experiences and expression of opinions were taken as meaningful and grounded within the social and cultural framework of the participants. While recognising the special qualities of qualitative research and its impact on both, the researcher and participants, the quality of the investigation was still of critical concern (Schensul, et al., 1999). To demonstrate the reliability and validity of the findings, the research process integrated triangulation, appropriate instrument development and analytical techniques and an audit trail.

### **2.5.1 Triangulation**

Triangulation involved using a combination of methods (focus group discussions, in-depth interviews, participatory diagrams), researchers and data sources. Triangulation was important for highlighting a variety of perspectives through numerous information sources. Data was validated through multiple and pre-tested

research instruments and the inclusion of several researchers (local and non-local). The role of the local field assistant surpassed mere translation to also acting, as Pepall, Earnest and James (2006, p.47) note, as an advocate and cultural broker. The field assistant assisted in the development of appropriate and relevant research questions, ensured continued access to the community, held extra community meetings in her own time to overcome initial misunderstandings about the research, and minimized a more general risk of western cultural bias during the research process.

Triangulation involved repeated questions, discussion and observation. Different techniques were not used to compare information gathered from one technique with another, but to develop a complex picture of a phenomenon being studied which might not be possible if only one method was utilised (Rice & Ezzy, 1999). The goal was to use each method so that it contributed something unique to the researcher's understanding of the phenomenon under study (Rice & Ezzy, 1999, p.76). As Wadsworth (2000, p.653) suggests, combining differing research methods produces a more complete picture, not by providing access to the "truth" but by increasing recognition and understanding of the diversity and complexity of experiences.

### **2.5.2 Rigour**

The concepts underlying this research build on previous international research as outlined in Chapter 1. This research shows conceptual and methodological rigour. It uses qualitative methodologies, which are consistent with the research goal and objectives, presents logical findings and provides evidence on which understandings and interpretations are based. Triangulation and logically designed research instruments, combined with multiple coders during data analysis, contribute to the reliability of the data. Dependability of the findings was confirmed throughout the data collection process when the main themes were discussed at length among the research team and raised with participants to validate that they were a reasonable account of their experience (Pepall, et al., 2006). Further confirmation will be achieved by peer reviews and other relevant audiences agreeing that the conclusions and interpretations are valid.

### **2.5.3 Construct validity**

The researcher was familiar to some extent with the characteristics and patterns of behaviour of the population. This came from living and working for several years in the area, by creating networks and relationships and by being part of a working environment that was conducive for learning. This background helped to avoid or address some of the misunderstandings (such as reasons for non-participation) between the researcher and the study participants throughout the research process. Informal discussions with community members and within the research team ensured that the terminology and expressions being used in the study would have the same meaning and frame of reference for the people who were to answer the questions.

### **2.5.4 Audit trail**

Research interactions are shaped by the social context of the research and the exploratory nature of the research encounter. As a result qualitative researchers become participants in the co-creation of knowledge. Therefore to assess methodological and analytical decisions, the researcher carried out an audit trail (raw data, methodological notes, instrument development). An audit trail enhanced the credibility of the research and gave strength to its reliability as a source of information for decision-making and future research.

## **2.6 Method(s) of data gathering**

Qualitative methods attempt to capture individual and community definitions, descriptions and meanings. By applying qualitative methods to women's health research, women's own perspectives and definitions of health were accentuated as was the social context in which health was experienced (Wadsworth, 2000). Qualitative research is inductive in its approach, moving from observations and open questions to more general conclusions. The goal of this research was to produce data that was conceptually, not statistically, representative of people in a specific context. The data was collected using methods consistent with the research design. The study design was flexible and responsive to changes in the field but focus group discussions, in-depth interviews, photo narratives and participatory diagramming were the principal data collection instruments used.

### **2.6.1 Freelisting**

A flexible study design allowed for the exclusion of methods that were inadequate for meeting the study objectives or were ill suited to the cultural context. Each methodology was piloted in Wegior village and, together in-depth interviews, group discussions and diagramming exercises, freelisting exercises were trialled. Freelisting is used to elicit from members of a social group relevant items which are of the same domain or category (Ulin, Robinson, Tolley & McNeill, 2002) and which can be compared, counted or ranked. The main purpose of the freelisting exercise was to obtain the membership list for a domain, for example “list all the work women do,” thus exploring women’s perceptions and specific categories of knowledge (Fleisher & Harrington, 1998; Flinn, 1998). Implicit to the technique was that the domain exists as part of the language, culture or society and observations and experiences were classed into a domain by more than the individual respondent (Shensul, et al., 1999). Freelisting was to be used both as a discrete research instrument and as an icebreaker to an in-depth interview.

Freelisting is commonly used in rapid assessment studies (Bernard, 2006) and is a simple technique which can reduce the time used to collect data (Fleisher et al., 1998). This was not the case in the pilot study. When the researcher asked a participant from the 25 to 45 age group to list her “most important problems faced” or “ways to improve health,” she did not make a brief qualitative “list” in reply. Instead, one point, such as a specific problem faced (violence, death of a family member), would become the focus of the conversation and discussed at length. She used examples based on experience and her response was grounded within the immediate local environment and her social relationships. It was not a rapid exercise, which could then lead to deeper questioning or ranking. Rather the free listing exercise itself became an in-depth interview. At first the researcher felt frustration at her inability to provide a concise response and attempted to redirect the conversation back to the freelisting exercise (“Ok great, that’s number two, could you list another one?”).

Despite the many examples of the effectiveness of freelisting (see Bernard, 2006; Flinn, 1999; Harman, 1999), particularly in rapid assessment and applied research, freelisting was excluded as a research instrument with participants in Patigo.

Interrupting and redirecting the participant's narrative was inappropriate and began to introduce interviewer bias during data collection. Individual participants did not recall their experiences as a list of things or issues for comparison. Over the course of several freelisting activities, the researcher realized that she was attempting to dissect particular beliefs and understandings, when in fact women did not speak about each point as a separate entity. Women constituted and expressed knowledge by direct experience, not by speculation or abstraction. Thus, each issue or item was interconnected, to be understood and examined as part of a "story," embedded within the social context. Although freelisting provided useful information on which to build further questions and identify initial themes for validation, in-depth interviews, group discussions and participatory diagrams (which involved a form of collective listing and participants sharing ideas) were less structured for participants and did not compromise flexibility or spontaneity. Freelisting might have been better placed as a methodology if the questions had been focused on more tangible things and experiences, such as types of food crops, everyday domestic duties or most common illnesses.

### **2.6.2 Focus group discussions**

Focus group discussions (FGD) enable a researcher to explore people's knowledge and experiences, providing a rich and detailed set of data about perceptions, thoughts, feelings and impressions of people in their own words (Ulin et al., 2002), in a relaxed setting with those who have similar views and experiences (Rice & Ezzy, 1999). Focus group discussions are also used in participatory action research, to "give a voice" to more marginalized groups, such as the poor, minority ethnic groups or women, who may be restricted from overtly expressing their view about their health and needs (Rice & Ezzy, 1999). Focus group discussions were included as a research method in this study because they enable discussions with a relatively small number of people, from a similar socio-cultural background and focus on a specific, often sensitive, area of interest (see Appendix V for discussion guide).

The defining, though most often unreported, feature of the method, is group interaction (Wilkinson, 1998 as cited in Pini, 2002, p.341) and Pini (2002) in emphasising the value of focus group discussions for addressing feminist research goals, contends group interaction can go so far as to diffuse power relationships,



enable the connection between individual and collective experiences and empower participants to challenge, question, critique and learn from each other.

Participants for focus group discussions were identified following a community meeting, with names of interested women, of all ages, collected and grouped together. Snowball and purposeful sampling were utilised to increase the number of participants per group. Two focus group discussions were conducted with young and adult women respectively (total of four), ranging from six to ten participants in each group, the variation reflecting the availability of women. One FGD was held with both young men and adult men.

Participants agreed amongst themselves on the time and site of the discussions, which were usually early morning or late afternoon, under, on the veranda, or in the shade of a participant's house. Focus group discussions ran, on average, for one and half hours, which reflected the need to balance sufficient time for covering the main themes with moderator and participant fatigue, interest and workload (Pini, 2002; Rice & Ezzy, 1999). Light refreshments were shared on completion of the interview and a group photo taken. A laminated, colour copy of the photo was later given to each participant.

A focus group discussion guide was used to direct the discussion although the researcher tried to "step back" and give women the opportunity to direct the conversation. Similar to Pini's (2002) discussion of her constant repositioning on a continuum that ranged from a directive to non-directive approach, I too experienced anxiety felt when in group interactions participants' discussions moved to an unrelated topic outside of the research interests. The researcher had to learn to balance her control over the direction of the discussion with respect for the flow of women's reflections and interactions. If discussions moved off topic but there was collective consideration of the issue, there were strong emotions conveyed (anger, sadness, joy) or it ignited the interest and participation of some of the more reserved respondents, the researcher continued with the line of discussion. It was important that participants felt relaxed and confident to talk. This flexibility contributed to the development of new and previously unconsidered lines of questioning.

Due to the localised setting of the research, all of the participants were known to each other. The effect of this was twofold. On the one hand conversations flowed freely and participants were confident to talk amongst friends and family. Women married to brothers or within the same family conveyed a sense of camaraderie in group discussions, understanding each other's experiences and needs. In some situations however, women were hesitant to talk openly about sensitive issues (such as polygamy, contraception and violence against women), particularly when in a group with their in-laws (husband's family). In one example, a participant (a second wife) stopped contributing to the discussion when other group members launched an attack against polygamy. Although she remained sitting with the group she appeared embarrassed, she withdrew her input and suffered their comments in the way that they were perhaps intended, as an indirect attack against her. In another example a participant disagreed about a point (financial support) but she chose to conform to the responses of the other members of the group and censor her view.

In small rural communities these psychosocial factors and the need for "sameness" may be magnified as participants may be concerned about future interaction and the need for harmonious relationships (Pini, 2002, p.346). On the rare occasions that the interaction between participants became charged and some participants showed their discomfort (withdrew), the researcher, who also felt concerned about the turn in the conversation, intervened to move the conversation along. One particular group formation which included three sisters-in law, posed difficulties for the woman who was married to another participant's brother. Although the group was seen as appropriate and formed by the women themselves, along kinship, locale and peer-group lines she found it difficult to be forthcoming about particular issues, such as violence, lack of economic support and polygamy. The dynamics demonstrated by the group reinforced the *social nature of the talk* (Wilkinson, 1998, cited in Wadsworth, 2000). Participants were positioned within their social world and this example played out some of the psychosocial issues affecting women's health (lack of family support, silencing affect of gossip, fear of retribution) and which had been discussed as a group.

However, the fact that participants knew each other, enabled them to draw on common experiences and stories from their shared daily lives, to show empathy and

concern over the death of a known relative, or laugh openly at a funny anecdote. Because much of people's lives were played out in the public village setting, among relatives as detailed in Chapters 3 to 7, intricate details of each other's lives were known. This gave participants scope to question each other about specific comments, to highlight contradictions and support each other in the conversation ("remember that time that you....."). At times it was difficult to pursue individual points due to the direction of the conversation being changed or instances of "small group" conversations occurring (Wadsworth, 2000).

Some participants dominated the discussion, particularly those who were very outspoken or had a leadership role in everyday life. In turn, other participants resumed a more supportive role and had to be actively encouraged by the researcher to contribute their ideas so not to find the discussion uninteresting or exclusive. Laughter and humour was a common thread throughout many of the focus group discussions with women laughing most frequently in discussions about relationships with their husbands or when considering a reversal of gender roles, making the individual experience collective (Pini, 2002). Humour could indicate solidarity and trust that the information revealed would not be shared outside the group or was used by participants (and the researchers) as a coping mechanism, to relieve initial tension or nervousness or when exchanging sensitive or serious stories, such as when discussing interpersonal violence (see Wilkinson, Rees & Knight, 2007 for an analysis of the role of humour in the examination of the relations and dynamics of focus group discussions). Topics that had been previously laughed about could in fact lead to a very sombre discussion.

Many of the sensitive topics that were raised in the discussions developed in most part due to participants appearing relaxed about talking when they knew that others had similar experiences and concerns. Kitzinger and Farquhar (1999) contend that focus group discussions provide a space and opportunity for sensitive issues to be raised and reflected upon in a more in-depth way than is normally not feasible in daily discussions. When apologising to the participants for taking up too much of their time, the researcher was regularly told "*no ken wari, olgeta dei mipela save wok, na dispela em chance bilong mipela*" (don't worry, we work everyday and this is an opportunity for us). Participants saw the focus group discussion as a "special

occasion,” and felt free to discuss topics that would be inappropriate or restricted in other forums (Kitzinger & Farquhar, 1999).

Some of the participants for in-depth interviews were identified from FGDs, while others also participated in a participatory diagramming exercise. Over the course of spending time with participants during the first discussion, often by the second meeting (and seeing them on other visits to the village) a good rapport had been established. This meant that some details of participant’s experiences and understandings emerged only in later interviews and conversations. Similar to Booth and Booth’s (1994) experience with in-depth interviews with vulnerable participants, a result was a greater level of involvement with research participants, such as assisting with pressing demands (family planning advice, transport, provisions for a sick participant admitted to the health centre) and it was difficult and undesirable on research grounds to sustain a detached stance.

### **2.6.3 In-depth interviews**

The in-depth interview was chosen as a research method because the interview style is informal and is appropriate to the context in its focus on participants’ own lived experiences, meanings and interpretations (Råheim & Håland, 2006). Rice and Ezzy (1999) reinforce that a good interview is achieved not only through technique and method but also out of an interest with how other people make their lives meaningful and worthwhile. A general interview schedule guided the line of inquiry rather than a structured questionnaire and this enabled the interview to maintain an open and conversational quality (Baker & Motton, 2005).

The study objectives guided the development of the interview schedule (see Appendix VI) and some questions also built on the preliminary analysis of data and some comments made by participants in focus group discussions and photo narrative sessions. Each question was also associated with a probe / follow up question(s) to encourage additional information and to show interest in what the interviewee was saying. Not all questions or probes were known prior to the interview and the interviewer followed the flow of the conversation and asked follow up questions to reflect on additional topics or points of interest raised by the interviewee.

The importance given to the exploratory nature of the interview and responding to the flow of the conversation aimed to lessen “interviewer control” (Bernard, 2006; Wadsworth, 2000) which was reinforced by questions not always being asked using the exact words or adhered to necessarily in a sequential order. However, researcher control over the research situation could not be avoided at times, as the researcher returned during the conversation to points for clarification, participants were brought back to the topic at hand if reflecting on an issue outside the scope of the research objectives, or new lines of information were pursued as they arose and integrated into the questions.

A good interview often resembles a good conversation (Rice & Ezzy, 1999). Although the researcher mostly listened, she verbalised her empathy and concern (“I’m sorry that happened”) and in some extreme examples responded in ways that may have affected the interviewees responses, such as when a participant talked about, as a second wife, being beaten by her husband (she had a black eye during the interview), followed by him burning down her house and the researcher was open about her opposition towards violence against women (“It’s good that you were able to get away from him”). The researcher also contributed some of her own experiences to the conversation, to show a sense of commonality and understanding during the research encounter, despite differences in age, class and ethnicity, and to satisfy much of the intense interest shown by participants about the researcher’s own life.

The researcher’s marital status and lack of children was a common topic of jovial discussion, particularly as it was agreed that the researcher must have the freedom to have a good career, but not at the expense of having children. The researcher became a co-participant in the discourse and responded to the problem of subjectivity rather than pretend it could always be avoided (Schensul, et al., 1999). Manderson et al. (2006) contend that structural factors (age, gender, class, linguistic style), together with the time and location of the interview, shape interview interactions and the development of social relationships, determining what is asked and how stories are told. Rather than seeing the interaction as invalid, attention must be given to the complexity and variability of experiences and the significance of social interactions in collecting and interpreting research data.

Many of the participants were known to the researcher prior to the interview, whether informally or having been a participant in either a FGD, photo narrative exercise or a participatory diagram. All focus group discussion participants were given the option of an interview with the researcher, and in some cases the researcher was approached away from the group by a participant asking for a one on one interview in order to present their point of view about sensitive issues (being a second wife, domestic violence) which were difficult to highlight during group discussions. As knowledge and understanding of the research increased in the community, other women approached the local field assistant requesting an interview so they could “tell their story.” On average, each interview lasted one hour. The majority of the interviews were recorded and transcribed, and for the few that were not (no tape recorder was available because it was an unscheduled interview), in-depth notes were taken and later expanded by the researcher and the research assistant.

On completion of an interview(s) the researcher and research assistant discussed the interview; why it worked well or why it did not, the key findings and observations. At times informal (for example discussions were held in the car when driving back to the office which could take anywhere from 20 minutes to over an hour), this process helped as a debriefing exercise and to identify new themes or inconsistencies in data. The research assistant as cultural interpreter was evident during these discussions and the formal process of data analysis. Often the feeling was quite euphoric if an interview had been successful and a good relationship and rapport had been developed with the participant. Although the majority of the interviews were recorded, interview notes were always taken and expanded as soon as possible and the data briefly reviewed for dominant themes. This process took place throughout the period of data collection with new themes being identified and explored and discrepancies highlighted and clarified during future data collection activities. Taking a written account together with the tape recording of interviews was important, as external noise especially that of children brought to the interview by their mothers, could affect the quality of the recording.

#### **2.6.4 Photo narratives**

Visual methodologies are becoming more evident in social research, encompassing media such as film, video, still photography, electronic visual media, and material artefacts (Guillemin, 2004). The photo narrative technique aimed to highlight women's perceptions of critical health issues at different points of the lifecycle. Using visual aids as a stimulant for discussion the researcher sought to explore associated themes, such as power relations and socio-cultural practices and gain insight into how women see their world in both its simplicities and its complexities (Guillemin, 2004, p.275).

The photo narrative instrument was chosen due to the extra dimension it could add to data collection methods. Showing an image, such as a culturally relevant photo (young girl selling goods at the market, an adult woman washing plates) can add structure to group discussions without compromising flexibility (Ulin et al., 2002). Individuals are able to organise and articulate their thoughts more easily with a clear point of reference. Questions that are centred on an image can bring a tangible dimension to what can be an otherwise abstract issue. This technique also allows participants to talk about the self in the third person and to use the subject of the photo as a point of reference on which to offer sensitive and potentially unacceptable opinions (Ulin et al., 2002).

Eleven black and white photos were chosen by the researcher sourced from "Changes, Challenges and Choices: Women in Development in PNG" (Cox & Daure, 1991), a Papua New Guinean publication which included a myriad of photos and associated narrative regarding the roles and responsibilities of women throughout the country. Photos relevant to the Sepik context were specifically sought (woman preparing sago, a young adult woman buying taro), although the women in the photos were not necessarily from the Sepik. Attempts were made to identify relevant examples of women for discussion, however the photos were fixed in a particular space and time, and constructed through various practices, technologies and knowledge (Guillemin, 2004).

Two different photos of women in the same age group were shown to the group and were passed around for the participants to see in greater detail. The exercise began

with showing a picture of the youngest age group (pre-adolescent girls) and continued to adolescent, adult and lastly older women (see Appendix VII for facilitation guide and Appendix VIII for an example of photos used). Although not a focus of the study, photos of pre-adolescent girls were added to this exercise to enable further insight into the contextual and interconnected nature of women's health issues throughout the lifespan, beginning with the lives of young girls. The women were given time to discuss the two photos amongst themselves. They were then asked to describe each photo; who was in it and what was she doing? They were then asked to think of some of the girls / women of a similar age in their village and to consider, what their life might be like. Further questions relating to the photo included; what sort of (health) problems might she have and what do you suggest could be done to help her? Finally, the participants were asked to consider what the girl's / woman's hopes for the future might be. Four photo narrative exercises were conducted in Patigo, two with adult women and young adult women respectively. On average the exercise lasted one and a half hours.

It is claimed that interpretation of images is subjective and pervaded with ambiguity, given interpretations may change depending on the time and space or may vary according to who is assessing the image (Guillemin, 2004). However, in this study, differing interpretations were welcomed and only helped to expand the researcher's understanding of the many diverse ways in which health and wellbeing can be understood and experienced among women. Of all the instruments utilised, the photo narrative technique was one of the most effective, both methodologically and thematically. It offered ways to help women feel comfortable in discussions and encourage them to talk about things of interest, to both themselves and the researcher. Women were relaxed, very interested in the (situation and life of) subject of the photos, and motivated to raise relevant issues for discussion. If women had reservations at talking about a sensitive topic, these were somewhat allayed when the picture was used as a point of discussion.

### **2.6.5 Storytelling**

In-depth interviews, focus group discussions and photo narrative exercises involved storytelling, an important social and cultural tool in people's lives. In discussions women would highlight or expand on a point or provide an example with a story.



This was particularly the case during photo narrative exercises when women would devise a story based on the photo (a teenager selling taro in the market, a husband and wife with holes in their clothes sitting with their children outside their house), and interact and create engagement with other participants through metaphor, rich imagery, suspense and emotion (Greenhalgh, Collard & Begum, 2005). The story had a plot, a beginning, a middle and an end, and an internal logic that made sense to the narrator and of significance for the audience (McCance, McKenna & Boore, 2000).

Storytelling provided an opportunity for “sense-making.” Through the shaping of their story, women were able express their own perceptions and judgements in order to make sense of events and actions and the links to past experience. The stories of women offered insights into what might have been, compared to what did actually happen, and hence they were able to consider different options and their likely endings (Greenhalgh, Collard & Begum, 2005). It allowed participants to share personal, often intimate aspects of their lives and relive past experiences through their narratives (Corbin & Morse, 2003). Despite the casual appearance of the group discussion, it remained structured and focused around specific questions and the participants controlled the amount of information provided in the response. Although a memory or conversation could prompt sadness for some participants, with one participant crying during her story, the distress was minor and short lived. Most participants commented that it was a unique opportunity to be able to relive their memories and experiences.

#### **2.6.6 Participatory diagramming**

Participatory diagramming was chosen as a research instrument due to the potential to facilitate, in practice, participants’ own construction of the categories and meanings that structure their lives (Kesby, 2000). It allows for the rapid generation of practical results that are of immediate use for discussions and analysis by both the researcher and participants. As a method, participatory diagramming attempts a reversal of more extractive research methods.

Participatory diagramming stemmed from the development of rapid rural appraisal methods that work to identify people’s needs, priorities and perceptions through a

process of research, reflection and action (IIED PLA notes, n.d; Cornwall, 1996; Suksai Narag, Daraaceh, & Menglang, 2003). The researcher had been exposed to participatory diagramming techniques such as body mapping (Cornwell, 1992; Hammar, 2008) and rapid appraisal methods such as problem trees in previous research with the PNGIMR. Participatory diagramming is embedded in the methodological and theoretical framework of action research. Participants are empowered to take greater control over the research process to generate potential solutions to their own problems (Meyer, 2006).

There are various techniques of participatory diagramming (matrix ranking and scoring, flow diagrams, force-field diagrams) through which criteria are created or the relative measurement of a given phenomenon expressed. Similar to focus group discussions, of critical importance is the interaction between group members that this method allows. Participants work together to produce data which is visual and diagrammatic as much as verbal or textual (Kesby, 2000a, p.1725). In rural communities diagrams are usually developed on the ground using locally available materials such as seeds, sticks, pebbles and household objects or representations drawn on the soil. The researcher and research assistant encouraged participants to analyze and learn from the results of the exercise and much was gained from participants being able to see the visual results of the research as they produced them. In this way the issue of action could be addressed by participants (Kesby, 2000).

The participatory diagramming technique of ranking and scoring was chosen as it was seen as an effective means for women to prioritize, compare and discuss their main health issues (see Appendix IX). Most of the women who participated in a focus group discussion or a photo narrative exercise participated in the participatory diagram exercise. This enabled the researcher to gain feedback on some of the preliminary findings and further engage women in the research process. As much as possible groups were kept the same, depending on the availability of women. Each exercise commenced with an informal focus group which involved a discussion about possible responses to the questions posed (identification of women's main health problems), and an explanation about how the exercise would be conducted. Emphasis was put on group interaction and consensus of identified health problems. A table was drawn on the ground, with up to ten columns and two rows.

When the element (problem) was identified and agreed upon it was written on a piece of paper and put in the first box of the first row. The health problem was also marked with material from the local setting. Violence against women for example was marked by one group of women with a fairly large stick (see Figure 4). Using local materials to symbolise the health problems was integral to understanding the problem from women's own experiences. When an object was decided upon, women were asked to explain why it was chosen and how it related to the health problem. When the second problem was identified, it was marked in the second box on the first row and so on. This process continued until the group considered that all of their main health problems had been identified.



**Figure 4.** Participatory diagram using local materials to identify young adult women's (married) main health problems.

The local materials used in Figure 4 give interesting insights into young women's perceptions and representations of health. The young women identified eight main health concerns, which were symbolised by materials from the local environment. Figure 4 shows the stage preceding the ranking of the health problems discussed below. From left to right, the health problems were identified and represented by participants and are outlined in Table 2:

**Table 2:** Health problems identified by young women and represented by local materials

<b>Health concern</b>	<b>Representation</b>	<b>Rationale</b>
Limited assistance with physical labour provided by a husband	Knife	A knife is used to weed gardens, cut bush, slice food etc
Financial constraints	PGK1 coin	Signifies low cash income
Heavy physical labour required to cultivate sago	Sago scraper (hoe)	The hoe is used to loosen the sago from the bark and is a physically laborious process.
Heavy manual labour associated with daily subsistence gardening	Vegetable leaf	Subsistence gardening involves the planting, weeding and cultivation of crops, of which green leaves are one.
Hard manual labour leads to illness, physical aches and pains	Medicine container	Represents treatment seeking for illness and disease.
Male control over women	Picture of a man drawn on the ground with a stick	Represents the participants' husbands
Violence against women	Piece of cane	Violence against women involves the use of weapons, including cane, sticks and knives.
Land dispute	Pile of dirt	Represents the ground associated with each clan

The elements that were identified were then ranked and attributed various numerical values (free-scoring) that indicated *relative* importance. Using pebbles or sticks, the values attributed to each element ranged from five pebbles for most important to one

pebble for the least important. In some cases the health problems were seen as interrelated and interconnected, thus it was impossible to differentiate one as being more important than another. These were marked with the same number of pebbles. The researcher then “interviewed” the diagram, encouraging detailed explanations of its elements and pursuing conflict and consensus that arose during the exercise (Kesby, 2000a).

A criterion was established for each of the identified health problems, beginning with the worst problem. Participants were asked “Why is this problem the worst? How does this problem affect you?” This process continued until the problem(s) with the least amount of pebbles, when participants were asked to discuss why the specific problem was not so important. Women were then asked to further discuss how the problems worked together to affect their lives. Lastly, women were asked to identify and discuss why they may have felt some problems were in their control to change or improve while others were not. During the “interviewing” of the diagram women responded to the researcher’s questions, analysing their own responses and modifying the diagram, in particular the scoring associated with some of the identified problems.

One participatory diagram with adult women was conducted during the pilot phase. In Patigo, two participatory diagrams were conducted with young and adult women respectively. The benefits of utilising the technique were apparent; the researcher and participants were able to interact directly; participants worked together rather than respond individually to questions and the data could be used as an immediate stimulus for further questioning by the researcher and for discussion and contemplation by the participants; it was less formal, “a unique occasion,” and at times, there was much whooping and laughter among the participants who were actively involved in the process of data collection; focusing on the diagram, together with their peers, was less threatening for participants and together with in-depth interviews, participatory diagrams were a powerful analytical device for understanding the linkages and relationships between health problems.

Women could stand up, walk around, look at the diagram from different positions, talk together, and source local materials from the immediate surroundings. Women

who were more reserved during focus group discussions appeared more relaxed and open to contributing their point of view (“what about betel nut and cigarettes as a symbol?”), and in their interactions with other participants and the researcher during the exercise.

There were some limitations to the exercise and participatory diagramming was not an easy option (Kesby, 2000a). The exercise ran on average for two hours and was facilitated by both the researcher and the research assistant. It was a demanding task for both the participants, who at times became restless and uninterested towards the end of the exercise, and for the researchers who had to observe and record group dynamics, actively listen and follow the “small group” conversations and encourage participants who began to withdraw to engage in the exercise. Written notes and photos of the diagram were taken to record the exercise.

The participatory diagramming exercise during the pilot phase ran for over three hours. Although the participants were extremely interested at the initial stages (focus group, identification and marking problems on the diagram), a further list of variables or criteria by which the first set could be judged (how women were affected) was generated and listed on the vertical axis (affects women’s bodies, increases workload, lack of services). This meant the exercise became drawn out and participants began to lose concentration and interest. Over ten health problems were identified and establishing criteria was a lengthy process, as was establishing how each problem was judged by the criteria. Criteria for judging health problems was intensely discussed, but not listed in future diagrams.

Some participants were confused about the process of developing the diagram and were hesitant to contribute their ideas. This was especially apparent when it came to marking a health problem with a relevant symbol. Where the research team was asked to assist, further explanation and examples were given. Interaction between the participants was vital to the process. In some cases, one or two participants, who were more confident and outspoken, controlled the conversation and the identification of health problems. To overcome this, the researcher keenly encouraged the other participants to take part, often asked them direct questions, and

reiterated the importance of group decision-making prior to the marking of a health problem on the diagram.

## **2.7 Data analysis**

Data analysis commenced during the piloting phase and continued throughout the data collection process. It involved initially reading, rereading, discussing and taking notes from the data (interview notes) collected during in-depth interviews, focus group discussions and participatory diagramming. This helped to immediately identify the emerging themes, unanticipated findings, gaps in the data, and work towards overcoming some of the methodological barriers (such as rumours and non-participation) while it was still possible to return to the field. Waiting too long to read and analyse the data, especially following the piloting phase would have hindered the revision and refinement of the research questions, terminology and methodologies. As the researcher came to understand the research problem more fully the questioning became more focused and specifically designed to check the emerging theory.

In-depth interviews, focus group and photo narrative discussions and discussion during participatory diagrams were transcribed and the data was more formally coded for emerging themes. The data was coded by the researcher together with the research assistant. This meant a code (label) was applied to a segment of an interview to identify general ideas and themes from the data. Subsequently, the common data for each identified code and theme was analysed separately, which gave rise to new sub themes, understandings and a more detailed analysis of the data. By identifying how commonly themes occurred in the data it also became clear whether certain themes tended to emerge in specific populations (young women for example) or more generally across groups. The software program Atlas-ti. Version 4.1 (Muhr, 1997) was used to manage the data and helped to make the coding process quicker and more consistent.

The researchers took a self-reflective approach. The research team were aware of the influence their personal biases and values could have on the research as well as the various meanings attached to their interactions with the community and the

expectations of study participants. The role of the researcher (age, sex, social status, ethnicity) was not seen as separate from the social setting or the research process. To minimize the effects of researcher bias, the researcher continuously reflected on the research questions and objectives and was aware of the affect that making a judgement could have on a participant's response. The research team actively avoided leading questions and interrupting a participant's story and sought to follow up on issues which were introduced if specifically relevant to the research objectives.

Throughout the data analysis the researcher and local research assistant grappled with the nuances and lenses of appropriate representation (Liamputtong, 2007; Sangtin writers & Nagar, 2006). All women used the pidgin phrase "*stap gut*" (in a good state / a good life / good sense of wellbeing), translated from the local language, "*wun'ei yukunba yerik'wa*" when discussing the construct of health. The local research assistant and local field assistant confirmed the appropriateness of the terminology, which was checked with participants during the pilot phase and during informal discussions with community members and the researcher's local colleagues. The phrase was used by the researchers to elicit women's narratives and meanings of health. The word "*helti*" was not used in everyday exchange. The dimensions of "*stap gut*" were broken down to create the picture of women's health.

Women openly voiced endemic financial difficulties "*sot long planti samting*" / "*painim hat long moni*" (poverty), talked about worry a lot "*bikpla wari / wari olsem tingting save kam strong*" (stress), discussed avoidance behaviors "*ino inap mekim wanpela samting*" as well as personal strength "*stap long strong long mi yet*" (resilience factors) and how they tried to address their problems "*mi inap long stretim*" (coping). They openly discussed their experiences of health services "*sik iwinim mipela em wanpela wei em inap long mipela go long hausik*" (health-seeking behaviors). I have addressed issues of equity, hope, social justice throughout this thesis as the women interwove these within the stories of their lives. I was able to reexamine my research position embedded in different constructs and apply it to the real life situation in the non-Western context of rural PNG (Tomaselli, Dyll & Francis, 2008).



## **2.8 Ethical considerations**

This study examined issues of women's health in Papua New Guinea which have long been downplayed or ignored. Based on a thorough literature review the potential contribution to knowledge about women's health in Papua New Guinea is significant. The methodology was chosen to address the research problem in a way that was socially and culturally relevant and analytically sound. The methodologies were adapted where necessary to suit the local context and participatory techniques and visual stimuli provided innovative ways to interest and engage women in the research process. Women were given the space to critically reflect on their knowledge and experiences and to share their understandings with others. The research was designed to ensure the selection, recruitment, exclusion and inclusion criteria were fair. Formal ethics approval was obtained in accordance with requirements from the Curtin University Human Ethics Committee and in country by the PNG Medical Research Advisory Committee (see Appendix X).

### **2.8.1 Informed Consent**

The researcher read a statement of information to all participants (see Appendix XI). Participants were informed about the purpose, procedures, risks and benefits and potential outcomes of the study. Informed consent was established in a relaxed, often lengthy and casual discussion prior to formal interviews taking place. Participants were not asked to sign the consent form (see Appendix XII). This was a more appropriate way of obtaining informed consent in the setting as firstly, many of the participants were illiterate and secondly, it was a less formal and obtrusive approach. This informal process, together with the researchers becoming well known in the community, contributed to the establishment of rapport and trust with participants. The researcher also explained to participants that their views were important and that their responses would not be judged as right or wrong. The researcher completed and signed the consent form to confirm consent was obtained. Because the research was conducted in the village setting, information about the study was provided at community meetings and verbal consent was obtained from village leaders and other interested parties prior to gaining individual consent.

### **2.8.2 Confidentiality**

Participants were assured of the confidentiality of information they gave and any identifying information would be concealed in published results. Permission was sought to record the interviews by tape-recording and in writing. The collected data was held in an anonymous form, with each name associated with a number, which was used (together with the date) to identify participants on demography forms, cassette recordings, and interview notes. All of the data was kept secure in a locked filing cabinet.

### **2.8.3 Right to withdraw**

Every participant was informed of their right to withdraw from the study at any time, without reason or justification. Initially some women did not attend a scheduled focus group discussion as they had heard the questions would be focusing on their private and more intimate affairs. In this case, the purpose of the study and the type of questions that would be asked was again explained. This was not only important for the overall perception, and potential survival of the project, but could contribute to women making an informed choice to withdraw and not a decision based on apprehension and rumours. All of the women came to participate in the study. Questions from participants, particularly prior to any data collection activity, were encouraged.

### **2.8.4 Avoidance of Harm**

Participants were made to feel comfortable by the researchers asking how they were, how many children they had and other culturally appropriate small talk. Although it was impossible to identify all risks, perceived risks to the participant, such as taking their time away from workload obligations, spousal suspicion, were fully communicated before consent was obtained. In order to avoid unnecessary stress, discussions were conducted in a language the participants felt comfortable with and which allowed them to express themselves clearly. This was particularly the case for older women. Participants were informed of the possible risk of giving up their time to participate, giving them less time for their other responsibilities. So that the

process of data collection would intrude as little as possible into the lives of participants, they were asked to determine the timing and place of interviews.

The researcher was well aware that many factors can arise that interfere with the timing and conduct of an interview, including other priorities of the participant. In some cases interviews were held early morning, late evenings, during the weekend, and very rarely on Fridays which was the main market day. On occasion the timing of an interview or focus group had to be rescheduled due to participants being busy preparing goods to sell at the market, church activities and associated travel and mourning the death of a relative. Two participants were replaced due to repeated non-attendance at scheduled interview times. The researcher recognized the pressure and constraints put on women's time and when participating in the study they were taking time away from work and other commitments. Participants with young children would generally bring them to interviews.

The interview surroundings were also assessed. Although interviews were generally conducted in a private setting (inside or under a house) with only the participants present, participants were informed that given the public context of the village setting, it may not be possible (or desirable, such as if a participant chose to have someone attend the interview with them) to avoid others hearing the conversation. Noise levels were occasionally too high and affected recording (rooster crowing, children crying, school children playing, heavy rain) yet it was not always possible to change the interview setting. In such cases written notes, which were expanded on following the interview, were relied upon. Other than the participants children, in most cases women were interviewed without other family members listening to the discussion or contributing their own opinions. Several women in the over 45 year age group had a family member present during an interview, often a grandchild in their care.

Participants were also informed of the sensitive or personal nature of some of the issues that may arise during the interview. If a participant did not want their responses shared outside of the interview, the researcher was asked to be informed to ensure it was indicated clearly in the notes that certain responses should never be quoted or described in publications. The researcher had to always carefully follow

the interview conversation (including body language) in case it moved onto a sensitive topic, such as domestic violence. To avoid unnecessary risk and discomfort, sensitive topics were explored only if alluded to by the participants and questions were carefully phrased. If participants needed advice or support with a personal problem and there was hope that the research team could assist them, the tone and focus of the interview could be affected. During the pilot phase, young adult and unmarried women were desperate for family planning advice and access to contraception and saw the discussion as a potential avenue for information and support.

### **2.8.5 Benefits to participation**

The research provided an opportunity for women to speak about their health concerns and general sense of wellbeing. Giving women space to discuss health issues may in fact have allowed women to recognize certain aspects of their life which were important or that they may have liked to change. Furthermore, women may have learnt new things during the research process as well as felt secure in an informal and somewhat social setting, which enabled them to contribute their own ideas, values and opinions. This was evident by the number of women who approached the research team to participate in an interview and share their own experiences. However, it is the dissemination of results, directed towards improving policy objectives and service provision strategies for young and adult women that may contribute to the improvement of health of disadvantaged women, particularly the women from the Wosera that participated in the research.

Benefits to the research assistant included developing her research skills, ranging from logistics, to data collection and data analysis. Her knowledge of the health problems of women significantly increased and her confidence in her skills as a researcher, which included sharing her cultural knowledge with the researcher through the process of data analysis. In addition, the gender inequalities facing women became an issue for reflection, critical analysis and at times, frustration, ensuring her position in society as a potential agent of change and a strong advocate for women's rights.

## **2.9 Summary**

This chapter has outlined the methodological underpinnings to the present study. The qualitative design directed recruitment and sampling procedures. It was appropriate to the study objectives and relevant for the social context. A variety of data collection tools allowed for a unique insight into the health concerns of women throughout the life span and the flexible nature of the design allowed for a participatory, inclusive a non-threatening approach to the study. It allowed the researcher to assuage participant concerns and the inclusion and participation of local researchers offered significant cultural insights and added significant depth to the data collection and process of analysis. Future researchers are encouraged to take into account the learnings, benefits and challenges outlined in this chapter in order to develop an appropriate, valid and meaningful approach and methodologically sound examination of women's health in Papua New Guinea.

# CHAPTER THREE

## Publication 1

Accepted for publication in *Rural and Remote Health*

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### Beyond risk factors to lived experiences: Young women's experiences of health in Papua New Guinea

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Hinton, R., & Earnest, J. (2009). Beyond risk factors to lived experiences: young women's experiences of health in Papua New Guinea. *Rural and Remote Health*, 9(1257). Available from: <http://www.rrh.org.au>.

Dr Jaya Earnest contributed to the outline, provision of relevant references and the review of drafts, for publications undertaken with Rachael Hinton.

This article was peer reviewed, revised and published in 2009. A copy of the published article is included in Appendix 1.

### **3.0 Introduction to chapter**

Chapter 3 is the first of five findings chapters which have also been developed as discrete articles for publication. It provides an opening insight into women’s health perceptions and presents findings based on the narratives of 33 young women. In this chapter young women reflect on their own concepts of health. For this group of women, health is interconnected with the socio-cultural and economic environment and is embedded in the changing and demanding circumstances of their lives. There are suggested actions to be taken in response to these findings.

The connections between a sense of wellbeing and physical health are discussed further in Chapter 8 and the definition of health and wellbeing underpinning this chapter is outlined in both the introductory and discussion chapters. The WHO strategic framework recommended in this article is further discussed in Chapter 8.

### **3.1 Abstract**

#### **Introduction**

The health of young women in rural Papua New Guinea is often examined using individual-based risk factors which are decontextualized from the social and cultural relationships within which women’s lives are embedded. Understanding the health meanings and perceptions of rural Papua New Guinean women is important for bridging the gap between current health program delivery and the real needs of women. The objective of this study was to explore the health perceptions of rural Papua New Guinean young women and to identify points in the lifespan where support may be required.

#### **Methods**

Thirty three young women aged between 15 and 29 years were involved in the research. Multiple data collection methods within an interpretive qualitative methodology were used and included in-depth interviews, focus group discussions, photo narratives and ranking exercises. The study was conducted in a rural community in the Wosera district of the East Sepik Province of Papua New Guinea from mid 2005 to early 2006. Following a community meeting and targeted

awareness about the project to female youth, purposive and snowball sampling was used to recruit young women in the age of 15 to 24 years. The mean age of participants was 21. Single and married participants, unmarried mothers, school leavers and current school attendees were represented. Informed consent was obtained prior to sharing of women’s narratives. Data were categorized and analyzed for emerging themes and cross checked with participants for verification.

## **Results**

Young women viewed their health in the context of their social and cultural world and in terms of their wider life experiences. The main theme uncovered young women’s strong desires for independence. Young women shared that they depended on their parents for emotional support and material possessions and positive parental support provided young women with the opportunity to move towards independence. Freedom from economic constraints was identified as important for autonomy and having money was discussed as a requisite for good health. Young women discussed that building healthy relationships was integral for health. For single young women this was connected with having the freedom to spend time with friends and boyfriends. Married young women noted that their health was related to the quality of their marital and familial relationships and the level of support available to meet the demands of new roles and responsibilities.

## **Conclusions**

The young women’s narratives document the importance of the connection between the diverse health needs of young women and the social and cultural environment they live in. The role of connectedness with family, friends and community in young women’s lives is an important issue and can provide opportunities for the delivery of culturally appropriate support to young women in response to key transitional points in their health experiences. Health practitioners and policy makers in Papua New Guinea need to reconsider their assumptions underlying women’s health programs and interventions in rural areas and broaden their perspective of health to recognize the ways in which women’s personal experiences influence health.



## **3.2 Introduction**

Women in rural and remote settings face unique geographical, social economic and political challenges. They have diverse needs and health issues, which have historically been neglected by the health care system (Leipert & Reutter, 2005; Wathen & Harris, 2007; Winslow & Honein, 2007). Studies in women’s health have shown that health concerns the totality of women’s experiences throughout the life span, with the implication that overall health includes, but is not defined only by, reproductive health (Moss, 2002; Weisman, 1997). The health concerns and life circumstances of women in different age cohorts are not the same and as a result health systems work unevenly for women, failing to address specific needs across life spans, geographical circumstances and socio-cultural economic divisions (Wyn & Solis, 2001). Young and older women, for example, face age-group specific issues that constrain their access to appropriate care (World Health Organisation, 2003). It is necessary to understand and provide support for women’s health at critical stages in the life cycle when support may be required.

Globally epidemiological research has increased public awareness of risk factors associated with disease and has provided invaluable evidence in several areas of public health, for example: studies on intimate partner violence in multiple countries (Garcia-Morena, Jansen, Ellsberg & Watts, 2006) and data from large scale mortality studies in post-conflict nations-(Coghlan, Brennan, Ngoy, Dofara, Otto, Clements & Stewart, 2006). However this is limited in its capacity to reveal a holistic picture of health, especially young women’s health (Bannister & Schreiber, 2001). Attention is often focused on individual-based risk factors and epidemiological studies are decontextualized from the social relationships within which these risk factors occur (Link & Phelan, 1995; Schulz & Lempert, 2004). In addition, the studies do not portray the social, material and structural factors that influence risk behaviours and ultimately health.

### **3.2.1 Young women in rural Papua New Guinea**

Young women’s health in Papua New Guinea (PNG) is synonymous with discussions about HIV transmission and reproductive health. Current statistics reveal that the 15-24 year age group make up over 50% of the HIV prevalence, with

females in this age group having an estimated prevalence of 0.9% (WHO/WPRO, 2008; UNAIDS/WHO, 2008). As a result, reproductive and sexual health programs respond to adolescent health in relation to specific behavioural, social and environmental ‘risk factors’ and HIV and STI transmission risks. Young women are constructed as a risk group which has led to stigmatization, scapegoating, and overlooks differences within and across young women as a group (Hewat, 2008). There is also little examination of how these risks and relationships might be historically and economically driven processes that conspire to constrain individual agency and are rooted in a life of nutritional deficiency, illness burdens, heavy workloads, poverty, gender discrimination and unequal access to educational and other opportunities (Cohen, 1998; Wong, Li, Burris & Xiang, 1995). Although health related behaviour is to some extent within the control of an individual young woman, many of the social determinants of health are not, and her agency is constrained by the situations and statuses that are conferred on her (McDonald & McIntyre, 2002).

### **3.2.1.1 Risk factors and young women in Papua New Guinea**

Women in PNG face unequal opportunities in education, income generation and access to economic resources and property. Widespread and entrenched gender inequity leaves girls particularly vulnerable to abuse, exploitation and violence. Intimate partner violence has reached unacceptable levels (Amnesty International, 2006) and regional surveys have revealed that 67% of rural women have experienced violence from a spouse or intimate partner (Bradley, 1994; Toft 1986). More recently the Government of PNG stated that “young women all over the country are at high risk of rape, gang rape and other forms of violent sexual assault” (Committee on the Rights of the Child, 2003). Female literacy is low at 46% and only 6% of the female rural population reach an education level of Grade 10 or above (National Statistics Office, 2002). The low status of women perpetuates patterns of early marriage and frequent childbearing, seen in the total fertility rate of 4 (women 15 to 49 years), one of the highest in the Pacific (UNAIDS/WHO, 2008). Early marriage increases a woman’s vulnerability, disrupting educational opportunities and social ties. The prevalence and social acceptability of violence against women are major factors contributing to the poor health of young women in PNG (Amnesty International, 2006).

### **3.2.2 The research question – understanding women’s health beyond risk factors**

It is easy to see solutions as either medical or matters of health education (Macintyre, n.d). Problems specific to women’s health are complex and not attributable to either lack of knowledge or absence of services. Instead Macintyre argues that the health status of women reflects the complex and changing social and structural conditions of women’s lives. Little is known about rural Papua New Guinean’s women’s perceptions of their health needs, and even less about women’s health issues across the lifespan. This is a serious issue in a country where over 80% of the population lives in a rural area. In order to provide an alternative to the current biomedical discourse on rural young women’s health in PNG it was necessary to understand the health-related experiences of young women, as shared and narrated by the women themselves, and to examine health as it is situated within the socio-cultural context of women’s lives.

### **3.3 Aim and objectives**

The overarching aim of the larger study of which this article is one aspect was to undertake an ethnographic assessment of women’s health within the socio-historical context of PNG to: (i) identify if there are critical points in the lifespan affecting positive change in the health status of women; and (ii) ascertain if the gap between the perceptions of service providers and the real needs of women can be bridged. The objectives of this article were to examine young women’s perceptions of health and health-related experiences using a gender analytic framework and to identify priority areas for public service interventions.

### **3.4 Method**

#### **3.4.1 Use of the qualitative approach**

This study used rapid ethnographic assessment, a modification of traditional ethnography which accommodated a combination of qualitative and interpretive methods and a shortened period of time in the field. Rapid ethnographic assessment and interpretive methods enable researchers to learn about what is happening to individuals and groups of people within a specific setting and gain meaningful contextual data by paying necessary attention to social and economic factors, cultural

practices and local ecological circumstances (Bentley, Pelto, Strauss, Schuman, Adegbola, De La Pena et al., 1988). The methods create space for shared dialogue between researcher and participant (Denzin & Lincoln, 2008). Ten in-depth interviews (IDI), 2 ranking exercises (RE), 2 focus group discussions (FGD) and 2 photo narrative (PN) exercises were conducted. Questions centered on young women’s personal narratives and perspectives of their health-related concerns, with particular attention given to understanding these perspectives within the social context.

In FGDs and IDIs, open ended questions sensitive to the context were used to reveal what being healthy meant to young women:

1. Tell me about everyday life. What is a woman’s life like here?
2. When you say you are healthy, what do you mean?
3. What can you do to stay healthy? What is the most important thing you do to stay healthy?
4. Do you often think about your health? If no, what brings “health” to mind? If yes, what makes you think about it?
5. What are the (health) problems women (your age) face here? What problems are worse than others? How?
5. Does your mother face the same problems as you? If no, how are they different?
6. Is there something you do to overcome the problem of (name problem)? If no, how do you think this problem could be overcome?

Photo narratives added an extra dimension to focus group discussions (Ulin, Robinson, Tolley & McNeill, 2002), with photos of women at different stages of their lives (child, adolescent adult) used to stimulate discussion. Participants were shown pictures of women from a similar rural Papua New Guinean context and undertaking specific tasks or responsibilities (a young woman selling food at the market, a mother sitting with her children). Participants were asked to describe each photo, who was in it and what was she doing. They were asked to think of some of the girls / women of a similar age in their village and to consider what their life might be like. Further questions relating to the photo included, what sort of (health) problems might she have and what do you suggest could be done to help her?

Participants were also asked to consider what the girl’s / woman’s hopes for the future might be. Discussions also attempted to address issues of resilience, hope, aspirations, healing and empowerment.

Ranking and scoring exercises provided a useful means for young women to prioritize, compare and discuss their main health issues. A maximum of 10 health problems were identified collectively. Each issue was represented by an agreed item from the local setting, placed in a row on the ground. For example violence against women was represented by a stick. Each health issue was ranked using pebbles, and attributed various numerical values (free-scoring) that indicated relative importance. Values ranged from 5 for the most important issues to 1 for the least important. Emphasis was put on group interaction and consensus of identified health problems. Most of the young women who participated in a FGD or a PN exercise participated in a ranking exercise. This provided the opportunity to gain feedback, cross-check and validate some of the preliminary findings.

The first author (RH) carried out the majority of discussions in *tok pisin* (Melanesian Pidgin), the local lingua franca, with the assistance of a local research assistant. The local assistant was from the area and had been working as a health researcher in the study site for several years. Several young women chose to speak their first language (*Ndu*) and in these cases the discussion was facilitated by the research assistant with the support of a local field assistant. The research assistant assisted in the interpretation of cultural understanding and meanings and emerging themes were discussed with the local field assistant. Cultural interpreters increased reliability of the data collected as they clarified terms and local nuances, assisted the first author with translations where needed, conducted “member checks” with key informants and were able to respond to participants’ questions in a meaningful and sensitive way (Liamputtong, 2007).

### **3.4.2 The study site**

The research site was a village in the Wosera district, East Sepik Province of PNG. The research was carried out from mid-2005 to February 2006 and was part of a larger study examining rural women’s health within the context of women’s lives at critical stages in the life cycle.

The Wosera is part of Abelam territory, an ethnolinguistic group occupying the southern foothills of the Torricelli Range the Sepik River. Abelam clans are patrilineal kin groups and several clans are represented within each village (Winkvist, 1996). In the Wosera it is common for women to perform the majority of daily domestic duties and subsistence work. Women’s health and social development statistics are poor due to entrenched inequalities, multiple role responsibilities and because the status of women is lower than that of men. The payment of brideprice in which a woman’s fertility and labour are acquired from her father, entails husbandly authority over a woman (Amnesty International, 2006; Macintyre, n.d). Of the rural population in the East Sepik, in 2000 only 43% of women were literate (National Statistics Office, 2002). There is a heavy reliance on subsistence production for household consumption. Cash earning opportunities are limited, evidenced by low per capita incomes (Curry, 1999; 2005; Curry & Koczberski, 1999). In 2004, antenatal coverage in the Wosera was recorded at only 48% (National Department of Health, 2005), below the 2006 national average of 58% (WHO/WPRO, 2008).

### **3.4.3 Participant recruitment**

Snowball and purposive sampling were predominantly used to recruit participants. Women were identified following a community information session and through word of mouth. Recruiting and gaining access to young women was initially challenging as many young women did not attend the community meeting. With the help of our local field assistant young women were targeted specifically, the nature of the study explained and existing misunderstandings clarified.

Single and married participants, unmarried mothers, school leavers and current school attendees were approached and made aware of the study. The snowball recruitment technique allowed for this diversity and the four-month study period ensured there was ample time for participants to talk of their experience with others and encourage some of the more uncertain young women to take part.

Although the age range classifying a young adult in the study was 18-24 years, it became more relevant to rely on social relationships and groupings, rather than actual ages. Self identification and social acceptance underpinned the sampling process and

six women under the age of 18 and six women over the age of 24 self-classified as a young adult. Oral parental consent was obtained by 8 participants under the age of 18. There was an even spread of the socio-demographic groups of young women who participated in each method. For example of the 2 FGD, 1 was conducted with young women who were married (with and without children) and aged mid- to late 20s, while the second was conducted with single women, in their late teens either currently attending school or no longer enrolled. Eight of the 10 IDI were conducted with single women, one of whom had a child. Three young participants were currently in high school.

#### **3.4.4 Ethical considerations**

The participants knew the purpose of the study before discussions took place and were assured of confidentiality. Consent was given orally and participants were not asked to sign a consent form. This was less obtrusive and also took into account high illiteracy levels. This informal process contributed to the establishment of rapport and trust with participants. Ethical approval was obtained in accordance with the requirements of the Curtin University’s Human Ethics Committee and the Papua New Guinea Medical Research Advisory Committee.

The authors were also aware of their own positions at all times. The first author who undertook the research has lived and worked for several years in PNG. She is sensitive to the social setting and understands the importance of presenting narratives that reveal women’s voices and that are embedded in landscapes that they live. The second author is from the developing world and works extensively with participatory and empowerment methodologies.

#### **3.4.5 Data analysis**

All IDI, PN exercises and FGD were audio-taped and transcribed verbatim for analysis. The process of analysis involved a deep immersion in the collected data. The first author and local research assistant read, reread and discussed participants’ accounts for emerging themes and issues requiring further questioning (Dageid & Duckert, 2008). From emerging themes, codes were generated and applied to segments of transcribed data to identify common categories of importance as well as unanticipated findings. The emerging themes were also communicated to the local

field assistant for her consideration, input and cultural contextualisation. The software program Atlas-ti. version 4.1 was used to manage the data analysis process (Muhr, 1997).

### **3.5 Findings**

#### **3.5.1 Socio-demographic characteristics**

The socio-demographic characteristics of the sample are presented in Table 3. Thirty three young women participated in the study and ranged in age from 15 to 29 years. Participants had an average education level of grade 6. Four young women were enrolled in grade 6 or above during the study period. One-third ( $n=11$ ) of participants were married and nine of these young women had one or more child. Three of the single young women had a child. Five of the 11 married young women had a village of origin outside of the study site; two were from neighboring villages, two from a village within one hours walk and one from another province, accessible only by air or sea. This diversity offered interesting insights and nuances into ways young women’s health needs were framed and prioritized in the context of their marital status and associated roles and responsibilities.

**Table 3:** Demographic characteristics of young adult women ( $n=33$ )

<b>Variable</b>	<b>Value</b>
Age(years) <sup>¶</sup>	20.9 ± 4.86
Educational status	
Never schooled	2 (6)
One to 6 years of schooling	15 (45.4)
More than 6 years of schooling	16 (48.4)
Marital status	
Unmarried	22 (66.6)
Married	11 (33.3)
No. of women with ≥ 1 child	12 (36.3)

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<sup>¶</sup>1 value missing



### **3.5.2 Young women’s definitions of health**

Young women typically spoke about ‘being healthy’ by drawing on descriptions from the social and material circumstances of their lives and their daily activities. Young women expressed the need to ‘have money’ to be healthy, identified during RE as their most pressing health priority and a point discussed at length by all young women.

Angela: If I don’t have kerosene I will worry. When I don’t have money I find it really hard. If I don’t have salt or kerosene, I will sit down and think a lot. How will I get money to buy these things? How will I look after my family? Women have a lot of problems finding money (FGD, 29years).

The nature of women’s social relationships and access to social support to mediate workload demands and economic constraints also determined good health and discussions centered on a desire for cooperative and caring spousal, friendship and kinship relations.

Leslie: I’m a young woman and I want to do my own thing. If I want to collect water, cook or go to the garden and harvest vegetables or cut firewood, I will do it. If my parents or in-laws force me then I won’t want to do it. I have learnt how to do it already and so I do it when I see there is a need. If they press me to do chores I tell them that I’m not a child, I’m a grown woman. Then if others hear what they say to me they will think that I am disobedient and then they might ruin my name and say that I don’t like to work (PN, 29years).

All young women expressed similar sentiments for independence. However a desire for increased independence was mediated by their dependence on parental and social support to meet their personal and material needs. Young women’s discussions of independence highlighted three interrelated sub-themes: (i) the balance between dependence and independence; (ii) the value of financial dependence; and (iii) building healthy relationships. The following quote by Sylvia provides a good illustration of the interplay between the three themes, and each is examined in greater detail in the discussion below.

I live with my parents and they don’t tell me off. They both give me money. When I want to go around with my friends they give me money. Sometimes when I want to go out they get cross. But generally, I have a good life. But if I go out with my group of girl friends at night my parents do get cross (IDI, 19years).

### **3.5.3 The balance between dependence and independence**

A woman’s workload was perceived to be unchanging and physically demanding. It involved water collection, the weeding, planting and harvesting of crops, sourcing and cutting fire wood, food preparation and cooking and the washing of clothes and cooking utensils in the river. Unlike adult women or young married women, young women who lived with their parents, had fewer workload responsibilities, although most were expected to help their mothers with domestic duties and with the care of younger siblings. Amy claimed she had freedom to choose whether to work or not:

When it comes to sago for example, sometimes I help my mother to harvest it, but sometimes I can’t be bothered so I just stay at home (IDI, 19years).

All single young women discussed that despite depending on their parents for care and emotional support, they wanted to establish themselves as independent and separate beings from their parents. Young women recognized their security was synonymous with their parent’s care. They wanted to be provided for, fairly treated and assigned few responsibilities by their parents, which in turn, would give them the opportunity to seek other pastimes. They did not want to seize independence by rebellion but by negotiating with their parents for greater latitude and freedom, as Michelle explained, “I do a lot of the work, I help my parents and then in return my parents give me money.” Their independence and desire for autonomy therefore was conditional on parental acquiescence. Everlyn expressed the link clearly:

Sometimes we help our mothers to cook. When they are tired we cook. Or if our mothers cook we can do other chores for them. And then they don’t get angry and they are happy with us. Then we get on well with our parents and they give us money if we ask for it and the let us go out (FGD, 22years).

Parental provision of social and material support would show a single young woman they were respected and cared for, and the result would be compliance and obedience. If a young woman felt neglected by her parents, her “*tingting bai bagarap*” (unable to think straight) and in desperation, she could seek alternative avenues of support from outside of the family. Young women believed this could lead to high risk behaviour, such as substance abuse and transactional sex, and exploitative personal relationships. Parental care and support was also valued by married young women. A mother was required to prepare her daughter for marriage by teaching her the fundamental domestic skills to manage her own household and family.

The act of engaging in a struggle between dependence and independence has been identified as a necessary developmental step towards adulthood (Bannister & Schreiber, 2001), but for single adolescent mothers, the absence of parental emotional and practical support could have serious mental and physical consequences. Two of the three single adolescent mothers were particularly vocal about the independence they sought from their parents. Adolescent mothers expressed their anger and frustration at the treatment they received from their parents and the degree to which their life had changed for the worse. They faced the early cessation of education, abandonment by their boyfriends and a stigmatized child. As with the stigma associated with HIV transmission in PNG, there was a pervasive retributive logic that laid blame on pregnant adolescents since they had defied traditional customs (Eves & Butt, 2008). They were forced to take on multiple workload tasks and because the young women were not in formalized relationships such as marriage, they had limited opportunities for help and support.

Michelle: If my brothers can help me to build a house my life will be good as I’ll have my own house. Like, now I live with my parents I face a lot of problems. If I had my own house I’d be in a good position. I’d have my own garden and I would go to the market and earn some money and I’d be able to provide for myself (IDI, 21years).

The participants also described considerable emotional and physical violence in their lives as is evidenced by Elsie’s account:

I don’t respond when he [father] yells. If I talk back then I will get hit and be in a lot of pain. So I just close my mouth and let him yell at me. That’s what I do, I don’t talk back (PN, 21years).

#### **3.5.4 The value of education and financial independence**

During interview, all but one young woman discussed money in relation to their autonomy and as a requisite for good health. The search for independence by having access to money was expressed in different ways. The economic needs of married young women were directly related to their new role and accessing the essentials necessary to maintain a household; food, kerosene, soap, clothing and their children’s school fees.

Single young women spoke about how having money created opportunities to connect with friends, family and peers, to access market resources, or to buy and share items such as betel nut and cigarettes. The connection between money and the opportunity to purchase items according to the standards set by their peers ran through several interviews. It was important to keep up with the latest style of dress, or to accessorize with hair products and nail polish and personal items such as clothing, laundry and body soap were a constant issue of concern. As Jane explained, she wanted to have the means with which “to look after myself.”

If you have money you will think about buying good food, spending time with friends at the market. Money is our support. If I have money I will be healthy, I’ll feel happy. If I go to school I know that I will have everything I need (IDI, 19years).

The perceived social and economic opportunities that a completed high-school (grade 10) or secondary (grade 12) education offered young women were seen as integral to health. Education was identified as a key strategy to improve current and future wellbeing and create socioeconomic opportunities. Eight of the single

participants, however, discussed the precarious nature of their dependence on the financial support of their parents to continue their education. Only 4 of the 8 were currently enrolled in some form of education, with the remaining 4 excluded, mainly due to high education costs and the parental preference for investing in male education. Access to secondary and tertiary education is limited; even where access is not a problem, the quality of the education provided is often low. Furthermore, an increasing number of youths leave school after completing grades, 6, 8, 10 and 12, and cannot find formal employment either in rural or urban areas due to lack of experience or qualification (Foundation for People and Community Development, no date).

### **3.5.5 Building healthy relationships**

Another aspect of the struggle for independence involved young women having the freedom to develop healthy relationships with their female and male friends. The young women described the value of being part of a wider support network of trusted allies who were experiencing the same struggles and concerns. Participants talked about the strong ties they shared with their friends, and there was a strong correlation between spending time with friends and feeling a sense of happiness.

Sylvia: When I go out with my friends I feel healthy, I feel happy. If I can’t go out and have to stay in the house I feel fed up (IDI, 19years).

Being happy was interrelated with all three of the themes discussed, and was often heard in conjunction with “*mi fri long.....*” (I’m free to.....). Happiness was associated with autonomy - being free to socialize, free from economic constraints, and free from parental influence.

Sue: When I spend time with my friends, I feel really happy. We tell stories about ourselves, we talk to each other, and I feel really happy (IDI, 18years).

Many single young women stressed the importance of spending time with their boyfriend. Socializing with an unrelated young man was regarded as an undesirable modern practice by parents and male siblings, as was wearing revealing modern dress, drinking alcohol, smoking marijuana or going to a ‘six to six’ disco party.

Young women eluded gossip, criticism and cultural expectations through secrecy, which allowed them to have boyfriends without getting caught (Buchanan-Aruwafu & Maebiru, 2008). Open affairs would likely result in a young woman being beaten by her male kin because of the shame of her behaviour, which reflected badly on them. Although the exercise of these meetings was often difficult, with go-betweens used to pass messages, young women made a clear link between having the opportunity to nurture an intimate relationship and a good sense of wellbeing. This link was expressed as a necessity, “*mi mas lukim boi fren blong mi na mi bai pilim hamamas*” (I must see my boy friend and then I will feel happy), and it was one aspect of their desire for independence that was most difficult to achieve.

Young women were aware that the pursuit of romantic courtship had its risks. Fear of pregnancy was a common health-related concern in young women’s accounts of their relationships with young men. As they negotiated the tension between desire for romance, companionship and assessing a potential husband, and the fear of stigma if discovered, the hidden status of the relationship ensured a lack of access to information and contraception (Hewat, 2008). Young unmarried women in this study were frequently refused family planning information or access to contraception by health workers and volunteers engaged in community-based reproductive and sexual health education activities. Several health workers and volunteers justified their actions to the first author explaining that they did not want to facilitate the promiscuity and sexual activity of young women outside the confines of the marital relationship.

Young married women’s struggles to build healthy relationships were discussed in terms of the types of relationships they had with their husband, familial kin and in-laws, and the different avenues of support available to them to meet the demands of their multiple responsibilities. In spite of her own desire to be cared for, Doreen now had the full responsibilities of an adult and she spoke about their need to be supported in their new role.

If we work together, if my husband follows me to the sago garden and we do the work together, or he looks after the baby while I do the work, when we come back to the village we get on together well. I feel happy (IDI, 25years).

All of the married young women recognized that their physical and emotional wellbeing could be enhanced by having a ‘good’ husband. This meant a husband who was non-violent and did not seek to control his wife’s movements and socialization.

Beryl: A big thing is when we want to go a play sport or socialize with friends, our husbands stop us and we don’t feel that this is a good attitude. We ask ourselves, why do they stop us from doing what we want to do? That’s what we think about and we worry about it. It’s a big thing for us (RE, 26years).

Angela: Sometimes men hit their wives. They make us bleed. They use their knives on us and beat us badly. Or some beat their wives with cane. A lot of problems occur because of this and we find it hard to respond. But we do consider leaving our husbands (RE, 29years).

Young women desired a man who listened to the requests of his wife, assisted in childcare and other workload activities and who supported the family financially, by sharing or saving any earnings. Married women ranked a supportive husband as their second most important health concern. Anna explained that having a supportive husband was an aspect of life that was integral for creating a positive sense of wellbeing.

From my perspective, I feel really good when my husband helps me and we work together. I feel encouraged and I think, because of his help, I am able to have some time to rest in the village (IDI, 21years).

In PNG a husband who worked regularly in the gardens with his wife and assisted with childcare was not typical however, and in order to cope with the new roles and responsibilities associated with marriage, most of the young women still sought support from their own maternal families. Although young woman expressed a desire for independence that could be achieved by marrying and living away from the familial household, they felt that residing in a different province, district and even village, could be an isolating and demanding experience in terms of their daily life

and existence with no kin to support them. However, as the marriages of the young women in the present study were contracted between partners in different sections of the same village or neighboring village, most were never far from their natal homes (Scaglione, 1990). This gave Anna much needed access to social, material, emotional and physical support at a challenging stage of the life cycle:

My mother comes and visits me here. Anything I need she gives me, like sago, vegetables, bananas. She goes and gets it from her garden and gives it to me (IDI, 21years).

### **3.6 Discussion – Understanding the links between health and lived experiences**

#### **3.6.1 Good health - a social and cultural experience**

Good health in rural PNG, as voiced by the young women is a social and cultural experience, not an isolated or individual condition. All of the young women viewed health in the context of their social world. The meaning of health was always embedded in descriptions of women’s connection with others, the demands of their gender roles and responsibilities and their capacity to meet pressing economic and material concerns, and motivated by their efforts at independence. There are similarities between descriptions of health by the women in this study and those mentioned by women in different cultural contexts, such as Cameroon (Defo, 1997), United Arab Emirates (Winslow & Honein, 2007) Wales (Walters & Charles, 1997) and Ecuador (Schoenfeld & Juarbe, 2005). The voices and narratives of young women in this study have drawn similar attention to the relationship of health to wider life experiences. It is these narratives that are absent in the current political and public health discourse in PNG.

Contrary to the current discourse on young women’s health in Papua New Guinea that is focused on risk factors and behavioural determinants of sexual and reproductive health, young women’s health needs were articulated in response to what Bannister & Schreiber term ‘struggles for independence’ in daily life and their connectedness to others most important and closest to them. Thus, the current approach that addresses risk behaviour has the potential to be perceived as alien and



irrelevant to the real life experiences of adolescent women (Bannister & Schreiber, 2001).

### **3.6.2 Connectedness and good adolescent health**

The link between connectedness and good adolescent health has been extensively considered and documented (Barber & Schluterman, 2008, Lerner, Almerigi, Theokas & Lerner, 2005; Roth & Brooks-Gunn, 2003). Being well connected to significant other persons (or institutions) can provide a sense of belonging, an absence of loneliness and a perceived bond with socialization agents, and is protective against problematic behaviour and poor health outcomes. If young people have mutually beneficial relations with the people and institutions of their social world they have a greater chance of a future marked by positive contributions to self, family, community and civil society (Lerner et al., 2005)

The young women in this study expressed their desire to be connected to others, their family and peer groups. Connectedness to the school institution and school friends was discussed as important for good health for some young women and supports other studies that have examined school connectedness as a protective factor for adolescent health (Blum, McNeely & Nonnemaker, 2002; Libbey, 2002). Happiness was associated with affectionate and communicative interaction and supportive and fair parenting. In the domestic environment this meant having parents that did not intrude on, exploit or manipulate a young woman’s independent self (Barber & Schluterman, 2008).

### **3.6.3 Developing healthy relationships with boyfriends and in marriage**

Participants romanticized and favored love-made marriages to the traditional practice of kin-arranged or preferred marriage. These relationships were discussed in terms of respect and cooperation, as well as psychological intimacy. The social and cultural context of these young women’s lives however impacted upon their ability to develop these types of relationships. Young women for example took great care to hide their pre-marital relationships from male siblings and parents as well as from public view. The social and emotional consequences of premarital pregnancy have been documented (Bennett, 2001) and as evidenced in the accounts of the young women in this study, manifest in low self-esteem, feelings of social isolation,

helplessness and powerlessness. It is now well known that being abandoned or stigmatized can force women into casual and commercial forms of sexual networking, adding extra health and social burdens (Hammar, 2008).

Married participants expressed frustration that their expectation of marriage, as companionate and supportive, was often not met. Respondents’ descriptions highlight the importance of understanding the effect of gender expectations on young women’s lives, their growing economic responsibilities as well as the new responsibility for the primary care of their families (Avotri & Walters, 1999). The married women in this study sought healthy and supportive relationships with their own kin, husband and in-laws in response to their gendered roles, financial insecurity and heavy workloads.

#### **3.6.4 Health and the socioeconomic status of women**

The link between health and the socioeconomic status of women is receiving more attention (Farmer, 2001; Hildebrandt & Kelber, 2005; Schoenfeld & Juarbe, 2005). The circumstances of want created an oppressiveness in young women’s lives and they struggled to meet their basic needs on severely restricted budgets. Continued access to education was tenuous for some and impossible for most. Unmarried mothers were particularly disadvantaged without a husband to assist in child rearing, subsistence labor or through paid work. Some security was felt in the support young married women received living close to their natal family.

### **3.7 Implications and conclusion**

This study has shown that rural young women have distinct health-related perceptions and experiences related to the social, economic and cultural circumstances of their lives. The results documented that health is related to gendered roles and responsibilities of women within their families and communities and not limited to the reproductive cycle and child-bearing. These findings are consistent with a recent study of Indigenous adolescents in Australia that shows vulnerabilities to ill-health are embedded in the social and cultural context, and related to educational constraints, drugs and alcohol and racial discrimination (Mohajer, Bessarab & Earnest, 2009).

To deliver effective health care, we argue that is not enough to focus only on reproductive and maternal health. It is essential that there is an examination of the challenges facing young women at various phases of their lives – when they are single, married or single mothers. The WHO strategic approach to improving reproductive health policies and programs provides a useful framework for the development of evidenced based policymaking for women’s health in PNG (Fajans, Simmons & Ghiron, 2006). Its three stage approach – strategic assessment and action research; identifying and addressing management, technical and socio-cultural resource issues that affect service delivery and quality of care; and participatory and collaborative decision-making among a variety of stakeholders – provides the scope to assess and manage women’s health within a broader context of health, explore viable program alternatives and encourage multidisciplinary stakeholder involvement. The methodology, with its systems framework and participatory process, has proven useful for assisting countries such as Bolivia and Ethiopia in the process of identifying health priorities and in the design and strengthening of health policies and programs.

The study revealed the complexities of the lives of young women, their agency and struggle for independence against entrenched social, cultural and institutional practices. There is also the need to evaluate the impact of these challenges faced on self-esteem, resilience, pro-social behaviours such as sharing, generosity and helping, and problem behaviour avoidance – aspects that build agency (Blum et al., 2002). Further exploration is required to understand the ways in which young women prioritize different relationships and health at various points in their lives.

Policymakers and practitioners should be required to identify and respond to key factors and transitional points in women’s health experiences (WHO, 2007). Given the role of connectedness, for example, in young women’s lives there is a need to further examine and communicate a small number of basic conditions parents, teachers, peers, health educators should attempt to facilitate in their relationships with young women (Lerner et al., 2005). This provides the opportunity to enhance parenting and teacher training skills in support of adolescent autonomy, respect for individuality, mutual trust and respect and positive discipline. Peers and family

members could also be trained as mentors to act as role models to motivate and spend time with young women. This could enhance established mentor-type relationships that some young women experienced with key family members. Mohajer et al.(2009) note that mentoring programs can provide a medium for family members to engage with youth, build their self-esteem and empower young people in a culturally acceptable way.

An alternative approach to women’s health would be to value women’s own accounts of their health, and to examine gender roles and responsibilities as they affect health. To ensure a better balance between the treatment of disease and infirmity, and health promotion and prevention efforts, greater consideration must be given to the many factors beyond clinical health services that contribute to rural women’s health. Health professionals in PNG must take up the challenge to reshape their understanding of how young women’s experiences and life circumstances influence their health and wellbeing.

### **3.8 Summary**

Young women perceive health as social and cultural experience, underpinned by their material circumstances and their connection and personal relationships with others. The health concerns raised by young women present a divergence from current biomedical approaches to adolescent health in Papua New Guinea. The gap between the health priorities of women and current professional approaches to women’s health is an issue for women throughout the lifespan and this is reinforced in Chapter 4. Chapter 4 builds on the findings of this chapter and presents an examination of adult and older women’s concepts of health.

# **CHAPTER FOUR**

## **Publication 2**

**Submitted for review to Asia Pacific Viewpoint**

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### **Assessing women's understandings of health in rural Papua New Guinea: implications for health policy and practice**

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**Submitted 20<sup>th</sup> December 2009**

Dr Jaya Earnest, contributed to the outline, provision of relevant references and the review of drafts, for publications undertaken with Rachael Hinton.

## **4.0 Introduction to chapter**

This Chapter builds on the conclusions presented in Chapter 3 with an examination of adult and older women's perceptions of health. The health of women is shown to be multidimensional, related to the complex conditions of women's lives in marriage and interconnected with women's social relationships. This chapter draws further attention to the divergence between current biomedical defined health priorities and the real health needs of women and suggests an alternative approach to addressing women's health in Papua New Guinea.

The relationship between psychosocial health and wellbeing has been outlined in this chapter. The discussion of social and economic issues has been referenced to the literature and examined in greater detail in Chapter 7. The argument for gender equality has also been justified. The analysis of the PNG policy context was kept to a minimum in this chapter, however, the recommendations in Chapter 8 provide further analysis of PNG policy and its relationship to women's health.

## **4.1 Abstract**

In Papua New Guinea, high female mortality rates are addressed by applying biomedical solutions. These solutions often ignore the complexity of women's histories, cultural contexts and lived experiences. The objectives of this study were to examine adult and older women's perceptions of health and wellbeing to identify priority areas for public service interventions. The study was conducted in the Wosera district, a rural area of Papua New Guinea from mid 2005 to early 2006. Rapid ethnographic assessment was used to examine the health concerns of women.

Twenty seven adult women and ten older women participated in the study. Health was not limited to one aspect of a woman's life, such as their biology or maternal roles. It was connected with the social, cultural and spiritual dimensions of women's daily existence. Participants also identified access to money and supportive interpersonal relationships as significant for good health.

A disconnect exists between women's understandings of good health and socio-political health policies in Papua New Guinea. The situation in PNG may also have

implications for health service delivery to different cultural groups across the Asia Pacific region. Health and development practitioners in Papua New Guinea must become responsive to the complexity of women's social relationships and to issues related to the context of women's empowerment in their programs.

## **4.2 Introduction**

Women's health is typically defined and planned by health care professionals and policy makers, with a focus on reproductive and maternal health. This has led to a predominately biomedical and western approach to women's health and a prioritisation of reproductive health issues and women's roles as wives and mothers (Avotri & Walters, 1999; Cohen 1998; Meleis, 2005). When women's health is compartmentalized into various factors such as access to health care, reproductive choices, screening procedures or dietary factors, a health issue is then targeted as a potentially treatable condition and examined as a separate domain. This is distinct from the social, cultural and spiritual contexts of women's lived lives (Polakoff & Gregory, 2002) and the significance of the health problem in women's life circumstances often remains unidentified.

Women's powerlessness to control the conditions of their lives and the correlation with poor health has been documented in different development contexts (Avotri & Walters, 1999; Macintyre, n.d; Polakoff & Gregory, 2002). Other authors have highlighted the importance of gender roles in the increase of vulnerabilities to ill-health or disadvantage within the health care system, particularly with respect to access, uptake and utilization of formal health services (Manderson, Mark & Woetz, 1996; Weisman, 1997; Wyn & Solis, 2001). Women face health and medical systems that are often culturally inappropriate and insensitive, gender-biased and class based (Daly, 1995; Winslow & Honein, 2007), and which often focus on one dimension of health (the biomedical) rather than addressing the whole woman to understand the multiple impacts on her health (Kelaher, Baigrie, Manderson, Moore, & Williams, 1998; Tannenbaum & Mayo, 2003).

In this chapter I provide an ethnographic case study that integrates the social, spiritual and biomedical issues that influence the health of women in Papua New

Guinea. The objective of this chapter was to examine adult and older women's perceptions of health and wellbeing using a multi-method qualitative interpretative approach to identify priority areas for public service interventions. Chapters 5, 6 and 7 provide further discussion on women's perceived health problems, access to services and ways of coping.

### **4.3 Perceptions of adult and older women's health**

The socio-demographic characteristics of the sample are presented in Table 1. Twenty-seven adult women and ten older women participated in the study. The median age of adult women was 38 years, ranging in age from 26 to 50 years. Older women had an average age of 60 years and ranged in age from 49 to 74 years. Literacy levels were low and 40% of participants had experienced the death of at least one child.

**Table 4: Demographic characteristics of 27 adult women and 10 older women\***

<b>Variable</b>	<b>Adult women</b>	<b>Older women</b>
Age (years)	38.5 ± 6.9	59.8 ± 9.1
Educational status		
Never schooled	5 (19.2)	8 (80)
One to 6 years of schooling	18 (69.2)	2 (20)
More than 6 years of schooling	3 (11.5)	-
Marital status		
Single	1 (3.7)	
Married	22 (81.4)	5 (50)
Separated	3 (11.1)	-
Widowed	1 (3.7)	5 (50)
No. of living children	4 ± 1.89	5.9 ± 1.2
One or more children deceased	12 (44.4)	4 (40)

\* Values are no. (%), mean ± SD, or median (interquartile range)

#### **4.3.1 Adult women**

Adult women's concepts of health related to the responsibilities associated with their multiple statuses and their role in undertaking the majority of subsistence and



domestic tasks. Adult women discussed their physically arduous workload and the effort to meet their multiple responsibilities. Their shared meanings of good health, strength, resilience and well being are presented here as three interconnected themes, physical and material needs, psychosocial needs and spiritual sustenance.

#### **4.3.1.1 Physical and material needs**

Participants were asked “what does being healthy mean to you?” Every woman mentioned that it was imperative to meet their physical and material needs for good health. Having money to meet these needs was the most pressing issue in the lives of adult women, and was the strongest theme to emerge. All adult married women referred to the interdependent nature of marriage, with husband and wife supporting each other to achieve an equitable and mutually beneficial relationship. Women expected their husbands to assist them in child rearing and subsistence labor as well as through paid work. Participants were adamant that if a man was a good economic provider, a family’s physical, social and emotional needs would be satisfied. While women were expected to provide for subsistence, men were seen to be responsible for “*kaikai blong stoa*” (food purchased from a tradestore), which consisted largely of canned fish, corned beef and rice, for both consumption and distribution to his family and relatives.

Women’s expectations of an equal and balanced union were not consistently met due to inequities in their marriage. This contributed to the respondents depending on their own ability to support their family in fulfilling their daily social obligations and needs. The women developed specific characteristics, such as determination, strength and resilience to overcome personal difficulties. When women were not “*sot long wanpela samting*” (short of anything), that is they had sufficient food, household items, money for their child’s school fees and cultural obligations, they perceived themselves to be healthy and to have a good quality of life.

#### **4.3.1.2 Psychosocial needs**

Psychosocial health encompasses the mental, emotional, social, and spiritual dimensions of health. For the women in this study, psychosocial health was underpinned by the concept of ‘wellbeing,’ and women considered their health as a ‘whole’. Satisfaction with life experiences, sense of self and level of happiness for

example contributed to a woman's sense of wellbeing. Women's psychosocial health and wellbeing was related to the nature of their interpersonal and marital relationships. It was common for respondents to describe the ways in which a husband should provide for his family. By doing so he would make his wife happy, "*stretim bel blong em*" (soothe his wife's anger) and overcome her feelings of frustration and resentment. On receiving this support, women could "think clearly", not be worried or "think too much," feel happy and well-balanced. Happiness was the most common emotion that women equated with being healthy. Given the importance of relationships to women's health, maintaining a sense of harmony within the nuclear and extended family was paramount for a woman's happiness. As Eve describes, violence and disputes within the marital relationships was a serious cause of stress and concern, and retaliation and confrontation was seen to be detrimental to women's health.

In my life, every day I'm happy. No problems, no arguments within my husband, we are happy every day. No violence within the family or with others outside the family. We are ok.

Balance and harmony in the domestic realm was related to the satisfaction and security that a woman experienced when her material and economic needs were met. Women desired practical, material and emotional support from their husbands and wider kinship network and a life free from violence. A woman's satisfaction also stemmed from the belief she had in her own capabilities and strength to overcome her daily struggles. When content, women discussed having a sense of freedom, with few concerns or worries as expressed by Carol.

I feel happy. I don't have another way of saying it. What do I have to go and do? I have nothing to do. I'm free, I'm ok.

#### **4.3.1.3 Religious sustenance**

The struggle to meet their physical, material and emotional needs was for some women integrally connected to their religious beliefs. The anxiety and worry associated with inadequate domestic and family relationships and constant workload

and financial burdens was alleviated by a strong faith. The majority of adult and older women interviewed discussed their religious beliefs in these terms.

A strong Christian worldview and a belief that God would provide helped women to confront the demands of their daily roles and responsibilities. Women experienced a sense of release from their daily struggles and gained a sense of comfort that their concerns would be resolved through prayer. The participants who spoke about their faith in relationship to their health conveyed a strong sense of commitment to their beliefs, and in turn this commitment was seen to provide a buffer against demanding socioeconomic conditions and interpersonal conflict.

Talking about God, I'm not really concerned, like, I don't think about things too much. I know that God will provide for me, He will help us in anything we need, so I don't really think about things a lot.

For Julie, her faith was redemption for having no faith in the past, "before, yes, when I was young I had a child, then yes, I was in a bad state. Now no, I go to church, I pray that I can leave all that behind, and now I don't face any problems." A bad state for Julie meant she was sexually active outside of marriage; she disobeyed her parents and experimented with drugs and alcohol. It was perceived as a form of redemption for past wrongs and by following the teachings of the church she could embrace moral reform and live righteously. Women who lived in violent, polygamous and unsupportive marriages expressed a strong desire for their husband to not only attend church, but follow the moral prescriptions of the church, renounce his antisocial behavior and make a commitment to a new life.

#### **4.3.1.4 Physical health**

Women were asked to consider if physical health was an important factor related to good health. When women's social, material and physical needs were met, women explained that they were also physically healthy. When women were asked what being healthy meant to them, unless describing an acute condition, factors relating to physical health were given a low priority in women's life circumstances and the broader health hierarchy. The minor physical ailments women described, such as headaches, nausea, body pain and tiredness, were recognized as physical

manifestations of a punishing workload and the worry and anxiety experienced by the women about the conditions of their lives.

Often women would relate a serious illness, accident or acute condition to social and spiritual, rather than physical causes. Respondents were willing to grant the efficacy of Western medicine for minor ailments, but if illness persisted, women would consider social, moral and relationship factors. A complicated birth for example was explained as being caused by disputes over the non-payment of brideprice. In such cases, Western assistance was thought to be lacking an understanding of the social and cultural dimensions of the illness experience (Frankel & Lewis, 1989; Koczberski & Curry, 1999).

### **4.3.2 Older women**

#### **4.3.2.1 Meeting obligations and expectations**

Significantly for this age group, health was tied up with the duties and obligations that they perceived in their position as an elder that the family unit afforded them. It was common for all participants in the study to reiterate the purpose of having children was to not only to continue the lineage but to provide support and care to parents in old age when they were physically incapable of caring for themselves. Older women lived in close proximity to their male children as well as their female children when they married within their village of origin. Although only one older woman had given up her own household and was living with her children, seven of the ten older participants had become increasingly dependent on their children and were financially, materially and emotionally cared for by them. The psychosocial impact of this support contributed to older women's sense of worth and happiness and it was evident that the time, energy and labor women had invested in raising their family was having its benefits and was being rewarded.

Several factors contributed to the intensity of older women's expectations. The respondents who were in their late 60s and early 70s were beginning to experience the onset of a chronic illness, such as arthritis and asthma, and reduced physical mobility. Unlike younger participants, most of the older women discussed their health in terms disease and chronic conditions such as difficulty breathing, body pain, malaria and headaches. Older women were therefore in a vulnerable position as

they had reduced capacity to provide for themselves and their families and they were becoming increasingly dependent on their children and other relatives for support, particularly during an episode of illness.

My children are here and because of them I am healthy. I don't walk too much. But if they leave me and I am here by myself, how will I walk around, how will I work? I feel pain in my legs.

Eileen's expectations of support increased with widowhood and after her siblings had died.

I think about my brother a lot. I'm here and who will help me? My brothers and sisters have died and I'm the only one left. I only had one brother and he has died. So I live with my children.

The older women in this study did not however demand that their expectations be met. Instead, older women's narratives revealed that they were marginalized, often forgotten or ignored, and vulnerable in their dependence on the acquiescence of their children.

I don't get angry. It's up to them, if they want to help me it's up to them. If they see me and what to give me something that's their choice. That's what I think. My daughter gives me money and I go to the market. My son doesn't though, but I don't worry about that.

The experience of overcoming many social and economic barriers and workload demands over the years, raising a family, supporting their husband and other relatives to contribute to ceremonial events resulted in the majority of older participants conveying a strong sense of self-reliance. Despite their growing expectations, older women still perceived it as their duty and responsibility to provide for themselves and their children. Not only did older women contribute to the work of their daughters and son's wives, they were also expected, unless they were physically incapable, to contribute to their own household. As the older women in this study had an average number of six children, the tasks of helping their

offspring were significant. For older women who were still physically fit, being responsible for their family's wellbeing, and bearing the burden of a heavy workload, was an unchanging aspect of their daily lives.

#### **4.3.2.2 Beyond material security**

Older women sought a sense of security that extended beyond their material and economic circumstances, and in some descriptions, beyond death. Older respondents enjoyed spending time with their grandchildren. They felt pride and security that there would be generational change and they desired to see the young succeed and replace them, passing on their blood, culture, knowledge and links to land (Lewis, 1990; Mallett, 2003). Developing a strong relationship with grandchildren also helped to overcome some of the isolation and helplessness older women experienced due to their reduced physical mobility and limited opportunities to socialize with others.

#### **4.4 Discussion**

Our study findings indicated that the factors influencing adult and older women's health were multidimensional, dynamic and embedded within the complexity of their lives. Women's descriptions of good health were based around the experiences of their day to day circumstances, the multiple roles they undertake, their social relationships and material conditions. Women in different parts of the world have similarly reported that their health priorities are interconnected with other aspects of their life and intrinsically dependent on the social and political context (Hildebrandt & Kelber, 2005; Kaddour, Hafez & Zurak, 2005; Leipert & Reutter, 2005; Walters & Charles, 1997). Whilst this study is conducted in PNG, it would not be surprising to find that similar situations occur in other parts of the Asia Pacific. In Australia for example there is dissonance between the perceptions of health providers and the priorities of Indigenous clients (Kelaher, et al; Shahid, Finn & Thompson, 2009). The experiences of the women in this study show the importance of serving women throughout their lives, extending the population served beyond traditionally defined reproductive years (15 to 44years) to include the whole life span of preadolescence, reproduction, menopause and old age.

The results document that health was inherently social, cultural and spiritual and all women prioritized people and relationships. Women were part of a nexus of complex social relationships – between spouses, siblings, parents and in-laws – and it is not surprising that this is the framework within which women's health was expressed. Women's relationships were historically stratified with links to many generations and influenced by personality, faith and sociocultural values.

Reproductive health problems and physical conditions did not figure prominently among the health-related experiences and discourse shared by the women. Their descriptions of the support they desired to meet social, cultural and economic demands and maintain good health highlight the gender constraints facing women in this study and the expectations placed on them to sustain and care for their families. Understanding the health of women in Papua New Guinea requires attention and sensitivity to the ways in which women's perspectives of health juxtapose with the realities of their daily life.

#### **4.4.1 Priority areas for intervention**

The women in this study reflected that improvements in the quality of social relationships and their connection to family, friendship and other social networks would contribute to good health. This aspect of health can be addressed with programs that promote family relationships, parenting skills, life skills and physical and psychological self-care based on building self-worth and empowerment. There is widespread support for the view that real improvements in women's health will not be achieved until the issue of women's empowerment and inequality is addressed (Moss, 2002) in a context specific way (Asthana, 1996). Women's narratives show the complexities involved with negotiating social relationships to improve socioeconomic circumstances. Therefore if the health of women is to improve, women's health programs must not only become responsive to the complexity of women's social relationships but ultimately directed at improving material circumstances. Further discussion of the link between socioeconomic constraints and improvements in rural women's health is provided elsewhere (Hinton and Earnest, 2010a).

Several national and regional quantitative and qualitative studies in PNG have shown the impact of violence, gender inequality and lack of access to appropriate healthcare on women's health (Amnesty International, 2006; Lewis, Maruia, Walker, 2008; Toft, 1986). In support of these studies, the authors reinforce that good health must be viewed as interconnected with women's entire life experiences. High maternal mortality rates reveal extreme inequalities in women's health within a health system neutral to the social, cultural, contextual, political and environmental conditions of women's lives (Mallett, 2005). Technological interventions alone will not reduce maternal mortality. The narratives of women in this study are further evidence of the disconnect that exists between women's understandings of good health and socio-political health policies in Papua New Guinea. Change will require a broadening of scope by the Ministry of Health, supported by major donors, to improve the focus and quality of new and existing programs that provide services to women in Papua New Guinea.

#### **4.5 Summary**

This chapter has discussed the ways in which adult and older women's health is situated within the context of women's lives. Women's narratives show that health is not narrowly defined but framed by the interplay of women's socioeconomic circumstances, gender relations and spiritual beliefs. Chapter 5 builds on the links between women's health and the social and material conditions of women's lives and explores the inequalities that stem from women's life circumstances and which ultimately impact on health.



# CHAPTER FIVE

## Publication 3

Accepted for publication in *Women Studies International Forum*

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### **The right to health: Overcoming inequalities and barriers to women's health in Papua New Guinea**

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Dr Jaya Earnest, contributed to the outline, provision of relevant references and the review of drafts, for publications undertaken with Rachael Hinton.

This paper has been peer reviewed, revised and accepted for publication. A copy of the published paper is included in Appendix 2.

## **5.0 Introduction to chapter**

This chapter examines the barriers to health which impede women's right to achieve the highest attainable standard of health. This chapter introduces a rights-based approach to women's health. It draws on women's experiences with violence, socioeconomic constraints and a disconnected health system to show how the inequalities and discrimination in women's daily lives impede their right to good health and wellbeing.

The definition of health as expressed by women and which underpins this chapter is broad. The intention is to understand how health is perceived by women. Although the causal link between social conditions and physical health is explored, physical health is not prioritized over other health outcomes, such as happiness or satisfaction with life. These are important measures of health for the women in this study. The definition of health and wellbeing provided in the introductory chapter can also be referred to here. Chapter 8 provides an in-depth discussion of the link between social context and health. Finally although the Millennium Development Goals are briefly discussed in the introduction as well as the conclusion of this chapter, more detail is provided in Chapter 8.

### **5.1 Abstract**

Few attempts have been made to examine women's health in Papua New Guinea using a human rights framework that puts women and their experiences with fear, abuse, oppression and discrimination at the core of women's health. This article describes the findings of a qualitative study examining the key determinants of women's poor health and level of access to appropriate health care in relation to the right to health. Three main themes emerged as significant barriers to health; 1) violence 2) heavy workload and lack of economic opportunities 3) limited use of health services. The findings show that women's familial, socioeconomic status and productive roles intertwine to threaten their right to health. These findings should challenge health practitioners and policy makers in Papua New Guinea to put questions of power, resources, vulnerability and discrimination at the core of women's health programming.

## **5.2 Introduction**

The right to the highest attainable standard of health is among a host of interdependent and indivisible rights guaranteed to all human beings under international treaties. The right to health is closely related to and dependent on other human rights that are determinants of health, including the right to life, liberty and security of person, the right to adequate food, housing and social security and the right to an education. Individuals rarely suffer neglect or violation of one right in isolation (Gruskin, Mills & Tarantola, 2007). The human rights aspects of health and the connection between the right to health and economic and social conditions was clarified in the International Covenant on Economic, Social and Cultural Rights ratified in 1976 and Article 12 asserts that “it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (ICESCR, 1976). This included measures to improve medical care together with a focus on health-enabling factors outside the medical realm (Solar & Irwin, 2007).

### **5.2.1 Examining the right to health**

Multiple human rights documents which include the International Covenant on Civil and Political Rights (1976), Convention against All Forms of Discrimination against Women (1981), Convention on All Forms of Racial Discrimination (1969) and Convention on the Rights of the Child (1990), promote and protect human rights as a prerequisite to health and wellbeing. Every government is now party to at least one treaty incorporating the right to health. The right to the highest attainable standard of health makes governments responsible for the prevention, treatment and control of diseases and for the progressive correcting of conditions that may impede the realization of the right to health (Braveman & Gruskin, 2003).

The determinants of health stemming from underlying social stratification, and the level of access to affordable, appropriate and quality health care contribute to a person’s ability to achieve the highest attainable standard of health. Globally, in most countries, there are those who enjoy a higher standard of health and quality of services and those who for as a result of civil, political, economic, social and cultural factors are more vulnerable to ill-health and have inadequate access to health-related services. Research has documented a relationship between health inequalities and

inequalities in income, education, occupational status and employment status (Bruner & Marmot, 2006; Pietilä & Rytönen, 2008; Siegrist & Theorell, 2006) and health related mediators of inequality and inequity include health behaviours, psychosocial resources, coping strategies and social support (Denton, Prus & Walters, 2004; Moss, 2002). Of critical importance is the recognition of gender as a key determinant of health inequities. While many of the social determinants of health are the same for women and men, because of the interaction of these determinants with gender, women and men experience health and illness differently (Cohen, 1998).

### **5.2.2 Where do women's rights fit?**

The Cairo International Conference on Population and Development (1994) and the Platform for Action of the Fourth World Conference on Women in Beijing (1995) were instrumental in solidifying the link between human rights and women's health, a link reinforced in international consensus documents (Gruskin & Tarantola, 2005). The Beijing report endorsed an approach to women's health emphasising improving the status of women and women's empowerment through education, employment and involvement in social development. Significant to this changing model of women's health was the goal of improving human rights for women and targeting the discrimination and gender inequalities that underlie women's health, including a focus on violence against women and increasing access to justice (Meleis & Im, 2002; Moss, 2002). There was a move away from seeing women's health as a biological problem that could be addressed solely through improved medical technologies, to a holistic and contextual model that recognized health as a product of the same forces that structured a woman's relationship to the physical and social world around her and could be addressed through social policies, programs and activist movements (Freedman, 1999). The commitments to the advancement of women given at Beijing and the recognition of women's human rights spelled out in Convention against All Forms of Discrimination against Women (CEDAW) and other human rights instruments since Beijing have not been realised in Papua New Guinea (Amnesty International, 2006). Women living in poverty continue to experience persistent inequalities and inequities and have little formal or informal power to effect structural change to improve their health. Unless international commitments and national policy documents are revisited and monitored carefully and the information used to hold governments to account, progress toward gender

equality will be constrained and the urgent needs of women will continue to be ignored (Meleis 2005).

### **5.2.3 Recognizing the right to health in PNG**

Papua New Guinea has a high level of aid dependency (Corner, 2008). Australia wields enormous influence over PNG because of the two countries' proximity, colonial history and Australia is Papua New Guinea's largest foreign donor. The Australian Government will spend AUD\$377 million in Papua New Guinea in 2009-2010 (AusAID, 2009). The size of this assistance alone allows the Australian Agency for International Development (AusAID) to dominate and monopolise the development and political discourse. Despite the severity of human rights abuses in PNG, the Australian government does not consistently press the government of PNG for improved human rights or integrate human rights in discussions of poverty reduction and sustainable development strategies (Asian Centre for Human Rights, 2008).

Despite an active women's rights movement in the Pacific region, women's issues are barely represented in national politics and government policies. Women in Papua New Guinea are excluded from decision-making at all levels, and the political landscape is dominated by men. "Traditional" culture and customary practice is invoked to justify gender discrimination, subordination and disqualification from political, bureaucratic and modern economic spheres (Macintyre, 2000). Two major studies on human rights in Papua New Guinea show widespread and systemic patterns of abuse perpetuated by police and endemic violence against women and children by male relatives and both known and unknown perpetrators (Amnesty International, 2005; Human Rights Watch, 2005). The threat of gender-based violence, particularly sexual violence, impacts on a woman's ability to move freely in the community, to use public transport, to access health and education services, and to travel to market or to the workplace (Amnesty International, 2006). Researchers have shown that women in Papua New Guinea experience high levels of intimate partner violence (Bradley, 1994; Lewis, Maruia & Walker, 2008; Toft, 1986). These women are denied the right to access justice, to receive reparation or to see their perpetrator punished. Widespread violence and abuse, together with a weak health system, high levels of poverty and socioeconomic inequity limits Papua New

Guinea's ability to meet its commitment to the Millennium Development Goals (MDGs) and contributes to women's poor health indicators.

Maternal mortality has gained global prominence as a human rights issue, indeed the commitment to improve maternal health that was made in the Millennium Declaration has become a central platform to international development efforts. In Papua New Guinea women's health statistics are a pressing public-health concern. The life expectancy of women is estimated to be 61 years (World Health Organisation [WHO], 2006). Women's maternal mortality rates in PNG are the highest in the Pacific region (870/100,000), compared with 236/100,000 in the Solomon Islands and 50/100,000 in Fiji (World Health Organisation/Western Pacific Regional Office [WHO/WPRO], 2008). A woman from Papua New Guinea is 200 times more likely to die in childbirth than a woman in Australia (4/100,000). Obstetric causes were the fifth leading cause of morbidity and inpatient care between the years 2000 and 2004, with a prevalence of 266 per 100,000 (WHO/WPRO, 2008).

A woman's right to health is not just about access to maternal and reproductive health care. Women in Papua New Guinea are dying at high rates because of chronic and entrenched inequalities, because women's health is not valued in itself and the status of women is lower than that of men (Macintyre, n.d). Few attempts have been made to examine women's health in Papua New Guinea using a human rights framework that puts women and their experiences with fear, abuse, oppression and discrimination at the core of women's health. This entails an examination of women's health within the broader context of human development in order to underscore the relevance of an array of factors, well beyond the health sector, that impact on overall wellbeing and health.

### **5.3 Barriers to women's right to health in PNG**

The themes that emerged from the research depict narratives of multiple health needs and show an unequal burden of women's domestic and productive roles, responsibilities and obligations. Three main themes emerged in the analysis of women's discussions of their health and its place within the social, cultural and

economic context of their lives: 1) violence 2) heavy workload burden and lack of economic opportunities 3) limited use of health services. It is not the intention of this paper to catalogue all the ways in which these issues impact on women's health. Rather, the point is to reaffirm that in any given place and time, women's health cannot be understood in a way that is detached and separated from these kinds of social forces (Freedman, 1999a).

### **5.3.1 Violence**

Violence affected women's lives throughout the lifecycle. Women experienced violence at the hands of their parents, brothers, sons and by their husbands and in-laws in marriage. As described elsewhere in Papua New Guinea (Macintyre, n.d; Wardlow, 2006), women experienced a high degree of surveillance, chastisement and social exclusion if the boundaries of custom and convention were breached. The main reasons young women gave for being beaten by their parents or male siblings was that they had been caught socializing with an un-related young man in private, an unacceptable modern practice, as was wearing revealing modern dress, drinking alcohol, smoking marijuana or going to a "six to six" disco party.

A premarital pregnancy took the familial abuse of a young woman to another level and involved sustained verbal, emotional and physical attacks, particularly in cases where no marriage ensued. Consistent violent treatment could result in a young woman leaving the parental home to stay, if possible, with supportive relatives. Ideally a young woman's return to the family unit would be negotiated, because in Alana's experience, the alternative had serious social, economic and health consequences.

When I was older, after I had started menstruation, I did what I wanted, if I wanted to go to a dance I would, whatever I wanted to do I would. Being able to go to a dance is important. I would come back to the house and my father would get a stick, spear, whatever and chase me. This continued on and on and he made me so wild that I left and moved from house to house until I ended up how I am, pregnant. So life is really hard now.

Male control over women emerged as a strong theme in discussions of intimate partner violence. Some adult women felt devalued by their husbands. Payment of brideprice entailed “ownership” of a woman by her husband (Amnesty International, 2005; Eves, n.d; WHO, 2005), and she was seen as “*samting nating*,” (unimportant, meaningless) other than to fulfil her responsibilities and obligations in marriage. The impact of this treatment on women’s self-esteem did not go unnoticed by Sally who explained:

Sometimes men want to be the head, they want to be the boss and put women down. When I want to look after myself and dress well, men are jealous for no reason. He does that to me and puts me and my ideas down so that I will become a “rubbish” woman. That is what they do.

As described elsewhere, the concerns and anxieties that arose from infidelity, polygamy and promiscuity were fuelling violence within communities (Haley, 2008; Haley & Muggah, 2006). Male suspicion of infidelity and jealousy meant a woman’s movements were restricted, as if she was “*long kalabus*” (in jail), her appearance was scrutinized and as a community police officer identified, the end result was a man verbally and physically assaulting his wife.

I see this happening a lot. Why they hit their wives is for this reason. They hit them because they are jealous for no reason about other men. A lot of men do it, especially young men. Young married men.

Men however claimed it was customary practice and their right to engage in multiple unions. Their descriptions of polygamous relationships however were quite different from the traditional pattern of polygamous marriage practiced by men who had significant resources and had gained status and prominence in middle life. For the men in this study polygamy was about sexual prowess and male control. Women were blamed for their husbands’ infidelity and for taking a second wife because, as a young man mentioned, she was “not looking after him properly (not fulfilling domestic obligations), not following her husband’s wishes, or she was unable to bear children.” Polygamy was seen by women to have inequitable outcomes due to men not meeting their obligations and fairly distributing their time, labour and financial



and material resources among their wives and children. The following quotation from a nurse was an acknowledgement of the relationship between violence, polygamy and poor health.

In terms of women's health, what I see is that for the past months some women, some of them don't live well because their husbands have married another woman and this causes violence within the family.

Esther stated that "these men from here, they are the bosses. We are their slaves." She recognized that men had greater freedom than women and expected their wives to meet their demands without question. Rather than working in partnership with a man who took the lead to provide for his family, women were expected to "come underneath" men. Women recognized that not all men abused their wives and some couples did of course achieve a marriage where they worked side by side and cooperated on joint endeavours. Participants claimed that the small proportion of men who assisted their wives to meet the demands of their daily workload and shared his earnings was also perceived to be the type of man who would never mistreat or "hit his wife."

Men and women agreed that men perform less labour relative to women and women received variable input into their gardens from their husbands. Although Adam recognized he was failing in his domestic obligations, as the following discussion shows, there could be serious social consequences if a woman questioned her position. A woman could expect a "panel beating," a colloquialism for physical violence, if she complained about her multiple responsibilities or her husband's inadequacies.

Adam: When a man doesn't follow his wife to the garden there will be problems. When it's late afternoon and she returns from the garden and you ask your wife for food she will ask "did you follow me? Did you help me with my work today?" This is where the problems arise, a lot of marriages break up over these issues. So at least we must work together with our wives.

Tony: If she doesn't cook our food then she will get a panel beating.

Andrew: That's where the problems start.

The physical and mental health implications of violence against women in the Wosera were significant. Women were beaten, verbally abused and locked out of their houses. Young and adult women recalled violent encounters that involved the destruction of their property, such as pots, plates and the ripping and burning of their clothes. If a woman refused to have sex with her husband, her “disobedience” was physically and verbally punished. Excuses such as a woman’s infidelity and not meeting her marital obligations were used by men to rationalize the violence in public. Women who were unable to become pregnant were also the object of their husband’s anger since “marriage is to have children.”

Several women in this study feared for their lives. Remaining in a violent relationship could result in serious injury as Angela and Beryl, two young married women discussed, and possible death, either at the hand of their husband (Kate) or by suicide (Beryl):

Kate: It was at a level that he would kill me. So that wasn’t good so I slowly began to leave him. If I stayed with him and he over time he became angrier and angrier, he could have killed me.

Beryl: We run away and go and stay with our parents or we go to court. Sometimes we think about hanging ourselves. He is beating me often, so we get these kinds of thoughts. I will hang myself and end my life.

Respondents identified that leaving a violent husband was not without its difficulties. The power imbalance and the socio-cultural and economic consequences of leaving a relationship that was perceived as risky could be far worse than the health risks of staying in the relationship. A woman’s decision to leave was therefore dependent on whether her natal kin would provide her with social and economic assistance. Patrilineal structures also determined that a child was a member of their father’s clan, with associated land rights and obligations. Esther took this into account when discussing her desire to leave an abusive polygamous relationship, in which she was the second wife.

I think a lot about leaving my husband, but then I think about my son. Because of our custom, I have a lot of brothers and if I take my son with me, there might be a problem in the future, there will be a lot of males and my son won't have a good quality of life. That's what I think about. I will stay with my husband until my son is five years old, then I will leave him with his father.

The findings documented here are consistent with the most thorough study of intimate partner violence conducted in Papua New Guinea by the Law Reform Commission, which showed that the two most common triggers of domestic disputes were sexual jealousy and a wife's inability to meet marital obligations such as cooking, cleaning and child-care (Toft, 1986). The women in this study were victims of male control, jealousy and promiscuity. Women lived in relationships characterised by physical and emotional abuse. These findings illustrate the struggle women had to keep themselves healthy when confronted with a harsh reality and the abuse of their rights in their daily lives.

### **5.3.2 Workload burden and lack of economic opportunities**

Women repeatedly stated that their workload was a major constraint to their health. The multiple responsibilities of a woman's workload involved the production of food crops, such as sweet potato, taro, corn and sago, firewood and water collection, the provision and cooking of food for domestic consumption and all laundry and childcare activities. A woman's workload burden extended to the constant struggle to find money for household items, clothing and children's school fees.

A man's lack of support and assistance to his wife to meet the demands of daily life were a constant cause of marital disputes. Each woman was aware of the inequities of the marital relationship and the unachievable expectations placed upon her by her husband to meet a heavy workload without assistance. An excuse regularly given by men was that a woman's workload was "*wok blong ol meri*," (women's work), and woman's role in marriage was to work hard and bear children and "not to relax."

In the two decades since the Law Reform Commission study, this research suggests that the changing attitude of women regarding social and domestic obligations noted

among urban women is becoming apparent in rural areas. As Toft (1986, p.15) found, urban women “have reassessed their role and rejected their previous subordinate position.” The women in this study regularly expressed concern about their position and were less prepared to accept their subservient status. Carly questioned for example, “why have I married this kind of man? One child will cry, another one I will put in the sling, another on my head, shoulders. It’s really hard.” It is also possible that the less submissive stance of women was causing younger men to react by asserting their authority in the marital relationship through violence.

The burden of a heavy workload was exacerbated by having to provide for a large family. Twelve of the 33 young adult women had one or more child. Adult women had an average of 3.9 children, increasing to an average of 5.9 for older women. It is not surprising that women complained about the physical and economic strain of having many children, since they were ultimately responsible for meeting all domestic needs. Children from large families were also likely to be undernourished, undereducated and poor (Defo, 1997).

Women of all age groups consistently described the stress, anxiety and worry they experienced about meeting the financial and physical demands of their daily lives. The circumstances of want created an oppressiveness in young women’s lives (Polakoff & Gregory, 2002), and young women struggled to meet their basic needs on a severely restricted budget. Adult women faced persistent demands and expectations to provide for their family in circumstances that were often isolating and beyond their control. The emotional problems and worry that was described in adult women’s accounts of their health was clearly emerging in young women’s narratives, with young women exposed to factors, such as social and economic stress, that affected their confidence, sense of independence and self-esteem. All participants described the physical manifestations of their stress and anxiety, which included headaches, inability to sleep, dizziness and weakness. Married women also complained that exhaustion and chronic aches and pains in their legs, arms, shoulders and lower back were evidence of the heavy physical toll of their constant workload demands.

### **5.3.3 Access to essential health services**

The women in this study faced a formal health care system that did little to meet the physical, emotional and mental health needs they identified and which gender-sensitive research highlights. A combination of government, churches and private organisations provide health services in PNG. Besides the formal health services, village health volunteers, traditional birth attendants and traditional healers also provide health services in some rural communities (United Nations, 2001). The 1974-78 National Health Plan committed the country to primary health care (PHC) (Connell, 1997) and established aid posts in rural areas, staffed with community health workers (CHW) offering basic services – anti-malarial tablets, aspirins and treatments for cuts and sores.

At the time of this study, the majority of the aid posts in the Wosera had collapsed, either closed, or were not staffed or supplied with medicine or equipment. There was no doctor available in the entire Wosera district and serious medical cases were referred to Maprik District Hospital, half an hour drive away, or to Wewak Provincial Hospital, at least three hours drive from the Wosera. Women accessed treatment for what they perceived as “minor ailments” from health volunteers, trained as part of the Save the Children Fund, Women and Children’s Health Project, or made the hour walk to the locally Catholic-run health centre.

As found in other developing country contexts (Kelaher, Baigrie, Manderson, Moore, Shannon & Williams, 1998; Tannenbaum & Mayo, 2003), women faced a system focusing on a singular dimension of health rather than addressing a woman as a whole person. Services for women focused on reproductive health services, namely Maternal and Child Health and antenatal clinic. As documented elsewhere (WHO, 2003; Wong, Li, Burris, & Xiang, 1995), these programs prioritized infant and child survival to the neglect of women’s health and they neither took account of the health needs of women who were not pregnant, nor accommodated women’s changing needs throughout their life cycle. Although the two nurses interviewed for this study made a connection between poor living conditions, stress and women’s ill-health, a lack of resources, limited staff training and time constraints restricted their capacity to respond to the psychosocial needs of their patients.

The constraints of gender and social, economic and cultural factors resulted in poor and often older women and girls being less likely to have access to appropriate care or to seek adequate treatment (WHO, 2003; Wyn & Solis 2001). Despite their ailing physical status, older adult women rarely sought treatment from the formal healthcare system, preferring traditional cures or basic treatment offered by the health volunteers. Lack of mobility, limited financial resources and lack of social support were the main factors inhibiting older women's access to health services.

Young women's accounts showed they did not access health care in a safe or comfortable environment. In PNG it used to be law that only married women could receive contraception from government clinics and that both husband and wife had to sign a consent form. Although the law has changed, so that a woman no longer needs her husband's consent, young unmarried women were entirely excluded from accessing family planning, let alone basic relationship advice from the Catholic-run health centre or family planning and health volunteers. Premarital sex was seen as culturally, socially and morally inappropriate and as such young women were labelled as promiscuous and criticised for their family planning requests. The end result was a degrading and insensitive encounter for young women. This is consistent with the findings of other studies that show the delivery of health care as being affected by poor communication and information exchange and condescending attitudes of health workers which work to intimidate and shame (Kelaher et al., 1998; Wathen & Harris, 2007)

Although there was a general appreciation expressed by participants about the availability of treatment, the health system was fragmented, involved long waiting times at poorly staffed and under resourced health centres and hospitals and put competing demands on women's time, as Carly's comment typifies:

Those of us who haven't washed the plates and went to the health centre, we think a lot about these things. We want to go quickly to the health centre, we have to wash the baby's nappies, wash the saucepans, plates. If I go in the afternoon then I will cook dinner in the late evening.

A consequence was that adult women delayed seeking medical care and suffered an illness in silence. Although they received little support in their domestic duties, women were expected to meet their responsibilities and not disrupt household organisation. Men were reluctant to allow women to participate in activities that would take them away from the confines of the village or garden and if a woman was not obviously ill and attempted to seek treatment at a clinic alone she would likely be accused of other intentions (Macintyre, 2000). Together with existing barriers to health care such as lack of time, knowledge and financial restrictions, women learnt to prioritize the wellbeing of others over themselves. Beth's account shows that this could result in self-care neglect.

We go to the health centre if we are really unwell. But if we are only a little sick we think about work and we go and harvest taro or sago. If we go to the health centre who will be there to help our mothers to do this kind of work?

The health system itself was also responsible for the perpetuation of social inequalities against women. Women who sought treatment for violence-related injuries were seen by health workers to have been somehow responsible for their perpetrator's actions. This did little to allay Tracy's fear of speaking out against her brother in-law:

My husband's older brother hit me with a stick. I felt a lot of pain so I came to the health centre. And the nurses asked me "what did you do that made him hit you?" I said, I don't want to talk about it because it will make him angry again and I'm afraid. I was thinking a lot about that. The nurses forced me to talk though. So I told them that my husband's older brother hit me on my hand and it became very swollen. I couldn't lift it. I was telling the nurse my story and then the nurse responded by saying, "what did you say to him that made him hit you?"

## **5.4 Discussion**

This paper has analysed the inequalities at the heart of women's health in Papua New Guinea that impede the realisation of the right to health. Women's work and the

physical burden of women's roles, marriage and risk of violence, and an unresponsive and inappropriate health service are major risk factors in women's health in developing countries (Meleis, 2005; Schoenfeld & Juarbe, 2005). This is consistent with the findings of this study which show that women's familial, productive roles and socioeconomic status intertwined to threaten their health (Walters, 1993). Women were situated in a social, cultural and economic environment that infringed on multiple rights, sustained unequal power relations and allowed for the perpetuation of violence against women.

Maternal death rates in Papua New Guinea are not declining despite a focus on maternal and child health by health workers, the national government and international aid agencies over a considerable period of time (Byford, 2005). The findings in this paper challenge the assumption that more hospitals and technological interventions will reduce maternal mortality. Women in PNG experience poor health because their health is not valued in itself and because women are discriminated against, abused, expected to meet unrealistic obligations, violated and denied access to appropriate and equitable services on a daily basis.

The findings show that the demands and restrictions that men imposed on girls and women and the threat of violence, if these were ignored or defied, were major factors limiting women's choices and right to health (Macintyre, 2000). Similar to Goicolea's (2001) study of Ecuadorian women and their accounts of "machisimo" and its relationship to gender violence, men took a number of actions to prevent their wives and daughters from having contact with those outside the domestic realm, which served to confine women to the narrow limits of their assigned gender role. The expression of violence took a large toll on the psychological and physical health of the women in this study (Amnesty International, 2006; Moss, 2002; Schoenfeld & Juarbe, 2005).

#### **5.4.1 Addressing women's right to health in PNG – using a rights based approach**

The international literature is growing on the ways the gender divide compromises women's ability to access appropriate and equitable health care (Cohen, 1998; Meleis, 2005; Vlassoff & Bonilla, 1994). Instead of viewing health services for



women through the lens of reproductive health, biomedical frameworks and the promotion of personal responsibility, a human rights framework would focus on the multiple roles of women and their experiences with fear, vulnerability, exploitation and oppression throughout the life cycle. Services sensitive to gender and human rights would see an improvement in provider knowledge of women's health problems and the socioeconomic factors determining patterns of health and illness, the sharing of information and joint decision-making (Khoury & Weisman, 2002). These would be positive first steps in the attempt to address women's vulnerability to inequitable care across the life span.

The level of violence against women in Papua New Guinea is a major obstacle to development and improvements are critical for progress towards the Millennium Development Goals (Meleis, 2005; WHO, 2005). As long as violence against women and the acceptance of violence more generally in PNG persists, programs aimed at improving women's economic and social status will be ineffective. The Government of Papua New Guinea, international and national civil society organisations and donor agencies must explicitly recognize violence against women and the social, economic and cultural discrimination facing women as serious human rights violations and a pressing development issue (Bradley, 1994). A person's gender, marital or relationship status does not change their right to have his or her right to health respected, protected and fulfilled.

#### **5.4.2 The way forward**

The major reason women continue to die from pregnancy-related causes in Papua New Guinea is that they are continually discriminated against as women throughout the life span. The severe neglect of women's health is a violation of their human rights (Gruskin, Cottingham, Hilber, Kismodi, Lincettob & Rosemand, 2008) and this violation must be investigated precisely to determine where the responsibility lies so that appropriate policy changes are introduced as a matter of priority (United Nations, 2006). Because the poor maternal mortality rates in PNG are socially produced, they can only be socially ameliorated, and as such, policies underpinned by the right to health must incorporate other crucial issues of women's health, not least the vital importance of reducing violence and improving the psychosocial health of women. This means that health policies must be centred on human development -

equitable, inclusive, non-discriminatory, participatory and evidenced-based - and which alleviate and are responsive to the social inequalities inherent in women's health, inclusive of maternal health. The principles and standards derived from international human rights treaties (both those specifically referring to women and gender, and those directed to civil, political, social, economic and cultural rights generally) should guide policy formulation and intersectoral programming in women's health, in all phases of the programming process (United Nations, 2006).

The poor health statistics and inequalities facing women in PNG must be used as a platform with which to galvanise the Government of Papua New Guinea to develop a legislative framework that takes into account the different and inequitable needs of women and men in allocating resources for health promotion, prevention and care. The issue is one of reducing inequalities in health, not only in access to health care and the authors suggest that a rights-based framework provides the necessary social and political leverage to advance the health equity agenda as promoted in human rights and legal frameworks. The integration of human rights and health might not be high on the agenda of Papua New Guinea and its major donors but as Gruskin, Mills & Tarantola (2007) emphasize, public-health efforts that consider human rights are likely to be more effective than those that neglect or violate rights. Papua New Guinea will not achieve sustained progress or achieve its commitment to the Millennium Development Goals without recognising human rights principles as core principles of health policy and health care delivery in the country.

## **5.5 Summary**

Women in Papua New Guinea experience abuse, injustice and neglect in their daily lives, yet addressing women's impoverishment and marginalization is not a high priority for the government of PNG. The damage that is afflicted on women's health by violence, economic and social marginalization and inappropriate health care sustains the inequality of women and is a striking reminder of their low status. The implication of this maltreatment significantly impacts on the psychosocial health of women in Papua and inflicts a huge burden on women. This aspect of women's health is explored further in Chapter 6.

# CHAPTER SIX

## Publication 4

Accepted for publication in *Health Sociology Review*

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### **“I worry so much I think it will kill me”: Exploring psychosocial health and the links to the conditions of women’s lives in Papua New Guinea**

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Dr Jaya Earnest contributed to the outline, provision of relevant references and the review of drafts, for publications undertaken with Rachael Hinton.

Whilst finalizing this thesis, this paper has been peer reviewed, revised and accepted for publication. The article is currently in press (e-publication) and will be published in *Health Sociology Review* 19 (1) 2010. A copy of the unpublished version is included in Appendix 3.

## **6.0 Introduction to chapter**

This chapter explores the poor psychosocial health of women in Papua New Guinea that is a result of the injustices and inequalities women suffer throughout their lives. Women are caught in poverty, experience violence and face constant gender constraints and challenges which as this chapter shows makes women vulnerable to stress, worry and anxiety. The psychological strains that women encounter in their daily lives must be given due consideration in interventions designed to address women’s health in PNG.

The conceptual link between psychosocial health and physical health is raised in the discussion of this chapter and expanded further in Chapter 7 and Chapter 8. For reference sake, the concept of wellbeing is defined in Chapter 1. Information on suicide rates in PNG is unavailable and this has been noted in the discussion.

### **6.1 Abstract**

The links between the social and material conditions of women’s lives in Papua New Guinea and their poor physical and psychosocial health has had limited examination. This chapter describes a qualitative interpretative study that examined the ways in which women expressed the links between their psychosocial health and the social, cultural and economic environment in which they lived. In-depth interviews, focus group discussions, ranking exercises and photo narratives were used to explore women’s experiences of health throughout their lifespan.

The innovative use of these qualitative tools and participatory methods provides new insights to challenge the discourse of health provision in Papua New Guinea. The findings document women’s experience and lives in a challenging environment that leads to “worrying” and “thinking too much” and which imparts and exerts a powerful influence on health. Women’s accounts illustrated feelings of powerlessness, helplessness and hopelessness when faced with financial constraints, unsupportive social relationships, violence and heavy household workloads. This chapter proposes the need for a thorough examination of women’s psychosocial health concerns to situate women’s health programmes and interventions within the context of their lives.

## **6.2 Introduction**

There has been limited examination of the links between the social and material conditions of women’s lives in Papua New Guinea and their poor physical and psychosocial health. Macintyre (n.d) recognizes the health status of women reflects the complex ways that oppressive patriarchal values maintain patterns of inequality and disadvantage based on sex. The growing dialogue and debate around HIV transmission dynamics in PNG has raised awareness about the impact of social conditions on health. Sexual health and female risk-taking behaviours are strongly affected by women’s social, cultural and economic situation, and specifically gender norms and relationships (Hammar 2008; Wardlow, 2002, 2006).

Women’s psychosocial health problems and forms of distress, such as anxiety and stress, are beginning to receive closer examination in the international literature for their links to the social and material circumstances of women’s lives. Mental health problems are examined not only as clinical outcomes of psychiatric conditions, but as social, economic and cultural in origin and in their influences on physical health (Avotri and Walters, 1999). The persistent demands and expectations placed on women to provide for their family in circumstances that are often isolating and beyond their control, resulting in what Doyal (1995) terms “idioms of distress”. Psychosocial health problems, such as anxiety, fatigue and depression, reflect the powerlessness and challenges women encounter.

### **6.2.1 Psychosocial health problems of women in the developing world**

The determinants of psychosocial health are gaining attention in discussion, dialogue and debate of women’s health in the developing world (Avotri and Walters, 1999; Schoenfeld and Juarbe, 2005). Poverty confronts women with a multitude of psychosocial stressors and material challenges linked to social status, social isolation and control over life circumstances (Hinton and Earnest, 2010). Financial insecurity, gendered roles and heavy workloads have been shown to impinge on Ghanaian women’s physical and psychological health (Avotri and Walters, 1999). In a recent study with comparatively educated and affluent Emirati women, women’s multiple roles, early marriage, frequent childbearing and polygamy were consistently linked

to increased fatigue and anxieties (Winslow and Honein, 2007). Women's accounts of their health illustrated feelings of hopelessness and helplessness when faced with overwhelming life circumstances. Women identified physical ailments which were related to the conditions of their lives and that they accepted as a normal, learning to believe suffering is their lot (Winslow and Honein, 2007). This reflects the psychological pressures, the inability to voice their distress and the complexity of the social, cultural and historical context of women's health experiences (Hou et al 2005; Schulz and Lempert, 2004). Walters (1993) has shown stress, anxiety and depression are experienced differently by women depending on their age, family structures, socioeconomic status, ethnicity, culture and occupation, as well as their clinical status. These variations between women bring much needed attention to the social production and social origin of mental health problems.

### **6.2.2 Psychosocial health and women in Papua New Guinea**

Poor social and economic circumstances affect women's health throughout the lifespan. Studies reveal women in Papua New Guinea experience high levels of violence (Amnesty International, 2006; Lewis et al, 2008; Toft, 1986). According to the government of PNG "Young women all over the country are at high risk of rape, gang rape and other forms of violent sexual assault, and the attendant fear accompanies them in many aspects of their daily life in urban and rural settings" (Committee on the Rights of the Child, 2003:45).

Intimate partner violence has reached unacceptable levels in Papua New Guinea (Amnesty International, 2006) and regional surveys have revealed that 67% of rural women have been hit by their husbands (Bradley, 1994; Toft 1986). The practice of bride price and polygamy is prevalent, reinforcing widespread expectations of patriarchal dominance and male control over women (AusAID, 2008). These practices are significant determinants of HIV transmission among women and only further entrench women's economic marginalization and dependence on men (Lewis et al, 2008).

The risk of violence, combined with the physical and psychosocial burden of women's roles are major risk factors in women's health in Papua New Guinea. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control

over life circumstances have powerful effects on health (Leipert and Reutter, 2005; Wilkinson and Marmot, 2003). Gender differences, that result in low status, powerlessness and oppression, have been cited as the basis of female suicide in Papua New Guinea (Booth, 1999; Counts, 1980) and elsewhere, including South Asia (Niaz, 2003; Girdhar et al, 2003) and Afghanistan (Rawi, 2004). However, health policy and women's health programmes remain aligned with safe motherhood, with the overall goal to "prevent illness, suffering and deaths among women in PNG through gynaecological, pre- and post-natal care and supervised deliveries" (National Department of Health, 2000, p.48).

There is a lack of available data on the incidence of mental health disorders in Papua New Guinea and the physical and psychosocial impacts of women's experiences on their health remain unexplored. Over 18 years ago Gillet (1990) called for an immediate investigation into the impact of mental health disorders in women in PNG, followed by a comprehensive plan of action. To date, this investigation has not occurred and a plan of action has not been developed. Women in Papua New Guinea continue to be deprived of necessary treatment and care.

Literature in PNG is limited in what it can tell us about the health-related experiences as perceived by women themselves. The objective of this study was to prioritize women's accounts and definitions of their own health-related experiences, as shared and narrated by the women themselves, and to examine health as it is situated within the socio-cultural context of women's lives using a qualitative interpretative approach. We explored women's health care needs across different age cohorts to understand the ways in which women were affected by the multiple circumstances of their lives. Emphasis was placed on the participants' perceptions and interpretations and by using qualitative techniques we were able to explore the complexities and meanings of their experiences and views in a more natural and informal setting (Liamputtong and Ezzy, 2005). It also allowed for the identification of inadequacies in care and a better understanding of whether the health priorities of women were being addressed.

### **6.3 Psychosocial health and the links to life circumstances**

Thirty three young women (18 to 24 years), 27 adult women (25 to 44 years) and 10 older women (older than 44 years) participated in the research. Young women had an average education level of Grade six, compared with an average of Grade four for adult participants and Grade one for older participants. One third (n=11) of young adult women were married and nine had one or more child. Three of the single young women had a child. The majority of adult women were married and had an average of four children. Half (n=5) of the older respondents were widowed.

Psychosocial health problems figured predominantly in women’s accounts of their health. In exploring the causes of poor health women drew on an idiomatic repertoire which was distinctive to all participants. The idioms of distress among the women in this study found expression in “wari” (worry), and “tingting planti” (thinking too much) and their associated symptoms. The idioms were used interchangeably by all women across the life span and capture what Doyal (1995) describes as the complex physical and psychological responses to the contradictory and demanding challenges associated with the social conditions of women’s lives. The financial constraints, unsupportive social relationships, violence and heavy workload demands women describe below were viewed through multiple lenses of gender inequity, social and cultural disparity and subtle forms of resistance (Hinton and Earnest, 2010a).

In presenting women’s voices and forms of distress I grappled with nuances and lenses of appropriate representation (Liamputtong, 2007; Sangtin writers and Nagar, 2006) and the participant’s shared meanings of worry, anxiety, unpredictability and resilience. Although “worrying” and “thinking too much” are standard expressions in response to social problems in Papua New Guinea, the analysis also revealed and documented that these expressions represented not only the anxiety and tension in the daily lives of women but also highlighted the unique strengths and resilience. Similarly women described many of their problems as a “hevi” irrespective of the type of problem experienced or causal factors. The expressions did not always capture women’s feelings of anger and unhappiness, the severity of women’s problems or the extent of their vulnerability and the underlying tensions of



resistance. However, I have used the idioms of “worrying” and “thinking too much” in this chapter as these expressions were used consistently by the women in the study and were interwoven within the shared stories of their lives.

### **6.3.1 “I think a lot about where I will get money”: Concern associated with resource constraints**

Young women’s narratives about their attempts to find different pathways to access money and to meet basic needs highlighted a mixture of frustration, anger and feeling “nogut” (bad). Lack of money was identified in the two participatory diagrams conducted by young women as their main health concern and the most frequent cause of worry. Represented in both groups by a PGK 1.00 coin (AU\$ 0.45cents) the following narrative of single young women presents their reasoning:

Beth: We need it for school fees, to buy good things, to pay for bride price, funeral costs, to pay compensation.

Rose: We need money for clothes, to buy string to make bilums (string bag), we need it.

Annalise: If we don’t have money we can’t go to the market and we just stay at home. That makes us feel worried.

Nita described how she would repeatedly think about the issue:

If I don’t have money then I will feel worried, like, I will think a lot. Where will I be able to get money from to buy what I need? This is what I think a lot about.

Single and married young women described the helplessness and hopelessness they felt about their situation and their inability to change their circumstances. This stemmed from the severely imbalanced state of gender relations that existed between men and women (Hammar, 2008). Single young women felt helpless to alter their position which kept them at the mercy of their parents. On the one hand they were a target of constant workload demands while, on the other hand, they were dependent on their parents for social and financial support. It has been suggested that when young people’s control over a situation is perceived negatively, worry can ensue

(Barahmand, 2008). Likewise when the young women in this study struggled to think through or cope with their frustration and lack of control over life circumstances, they expressed a vulnerability to worry. As Michelle expressed:

Sometimes living with my parents is good. If I work hard then they won't get angry with me. Then I will be ok. When they both get angry with me, then yes, I have many different thoughts. Like I feel I want to run away and go and stay somewhere else. I get these kinds of thoughts and I don't want to live in this house anymore. If they get angry with me, then that is how I feel.

The high costs of education were major source of anxiety for young women. Several participants had been being withdrawn from school by their parents due to a lack of financial resources. One young woman recalled a male sibling's education being prioritized over her own. Just under half of the young women who participated in this study achieved an education higher than Grade six, and only five were currently enrolled in an education course. Access to a high school education (Grade 10 to 12) represented freedom from parental pressure and was perceived by young women to increase their potential for future social and employment opportunities.

Despite parental restrictions and the perception they had unfair and high expectations placed on them, the death of a parent, in particular the death of a father, was identified by young women as a major health issue and a source of profound worry. Because single women derived their status from their father, in Anthea's opinion, it was a father's responsibility as "head of the household" to ensure the economic and material stability of the family. This was despite direct experience to the contrary and her dependence on her mother and siblings for financial support:

For children who have a father, their father will buy them what they need. For children who don't have a father, they will sit down and worry. With the death of their father they will worry, they don't have enough clothes to wear. They see others wearing good clothes and they will think if their father was alive they would also have good clothes.

Sylvia, a young woman who had a premarital pregnancy, was constantly the target of her parents' abuse and threats. Abandoned by her boyfriend and outside a formalised relationship such as marriage, she was forced to compensate for her "misdemeanour" by undertaking the majority of workload and household tasks in her family. As a single mother Sylvia faced an uncertain future. Despite her difficult circumstances, she feared her situation would be much worse with the death of her parents:

My wellbeing, it depends on if I find a husband. How will I live? Will I stay in this situation until my child is grown up? Will I live happily or not? If I stay with my parents and they die what will happen then? I don't know. How will my life be?

Many of the young married women described their attempts to manage the new roles and responsibilities that came with marriage. For Beryl this involved considerable psychological strain:

I have a husband. He doesn't follow me [to the garden] so I have negative thoughts and my thinking gets confused. I don't have any way to overcome this problem. I have thought so much about it that now my thoughts get really mixed up.

A difficult marital situation worsened for a woman with the death of her parents. Doreen had to manage the burden of her heavy workload and domestic demands without access to a broader support network other young married women could still depend on:

The girls my age, their parents are still alive and their parents can help them with their work. They go and help them and if they need anything their parents can always give it to them. Their brothers too, they go and help their sisters. For me, I don't have this support. This is my biggest worry. It is what I think most about. Every day, if I find it hard to do some heavy work, my thoughts immediately go back to my parents again.

**6.3.2 “I worry a lot about my life with my husband and sometimes it makes me want to cry”: Worrying about unsupportive marital relationships**

The descriptions of adult women show they were living in circumstances where life was a constant struggle with psychological strains and worry associated with financial constraints, a heavy workload and, in most cases, an uncooperative and unsupportive husband. Contributing to their concerns was a sense of uncertainty about the future and their ability to provide for their children's social, material and economic needs. During a participatory diagramming exercise adult women identified worry and thinking too much as an important health concern, represented by a ripped skirt. This symbolised the worry women felt to the point where they no longer took pride or care in their appearance. The following narrative from the exercise is indicative of most discussions of women's main health concerns:

Carol: Who will help me?

Pamela: A husband doesn't always support his family. He gives his money to another woman and not his wife and his wife will be sick with worry.

Irene: A husband must be with his wife. Who will help me with the sago? I worry and think a lot about this. If you are able to cut the sago palm then you will have to do it. If not, you will have to find it at the market. He needs to cut the big bush.

Vicki: Some women don't have a good life with their husbands. They don't have enough food, or money, no money for their children's school fees.

Several adult women who had been neglected or abandoned by their husbands and were solely responsible for their family's sustenance were particularly vulnerable. As Kate explained:

I feel really worried because I get no support from my [former] husband. He doesn't try to help me with any money for our son. It is solely for this reason that I try to find ways to raise an income. I need to find money for my son's school fees.

All married women reflected on the difficulties they had negotiating the marital relationship and their worry associated with the lack of assistance they received from their husband in all household and domestic duties. Many women were dismissive of their husbands. They resented the ways men expected women to be responsible for production and social reproduction, and to be a “good” wife, mother and in-law with limited social and economic support. Similar to Ghanaian women’s accounts of their work and health (Avotri and Walters, 1999), women were expected to provide for their family in circumstances which were becoming more difficult and that afforded them little control. The marital relationship was a constant source of worry, and women saw their husbands as the source of their problems. Male control over women emerged as a strong theme in discussions of intimate partner violence. Men stopped women from going out by themselves, inflicted violence against their wives and were suspicious of women’s activities outside the domestic sphere. Violence had a significant impact on the psychological and physical health of the women in this study as Beryl described:

Now when I go back to the house he will ask where I have been. He will ask what I have been doing and tell me that I need to feed him and the family before I leave the house in the morning. Then he will hit me. He will get his knife and come towards me. And I will tell him he can do what he wants. You want to hit me, that’s up to you. You can do whatever way you want to. You want to cut me? He is a really angry man.

Macintyre (n.d) asserts that perhaps more than any other factor, the cultural acceptance of violence against women is indicative of the naturalization of male dominance and reveals a deeply entrenched subordination of women. Women’s expressions of distress reinforced the normalization of male dominance and patterns of violence. Women’s use of the terms “worry” and “thinking too much” in response to male violence and conveyed women’s fears and anxieties but the idioms did not always sufficiently capture the severity of women’s vulnerabilities or the extent of their oppression.

Discussions with adult and young men revealed their sense of entitlement and ownership of women. They sought to control their wives movements, work and sexuality. In the same way Macintyre described men's justification for male dominance over women, the men in this study claimed the payment of bride price in which a woman's fertility and labour were acquired from her father, entailed husbandly authority and conferred a man the right to punish his wife who was not performing her duties as he determined. Children too were supposed to be cared for by women on behalf of their husbands. Male participants did recognize however the impact an unsupportive husband had on his wife's health and wellbeing as the following interaction reveals:

Peter: If a husband is doing nothing at home and his wife comes home after working all day in the garden and sees him she will get angry. Cooperation is a big thing, helping women with their work.

James: A lack of cooperation is the cause of marital problems.

Peter: If there is no cooperation between a husband and his wife, then a woman will face many problems. We men we need to work hard to raise an income. Then our wives will be happy. If she doesn't have clothes or money then she will worry.

Daniell: Every day my wife works in the garden so I have to make her happy by looking after the children while she works. If I don't do that and the children go to the garden with their mother and she has to look after them as well, then there will be problems. She won't be happy.

An uncooperative marital relationship led women to seek support outside of the household unit. Women across all age groups were vulnerable in their dependence on men for access to land and property and for having to rely on the compliance of others for support. It was a prudent woman who avoided a dispute with her natal kin or in-laws. The alternative would only exacerbate the constraints and instability of her position and restrict her access to broad social, material and economic support. This was particularly important for widowed or less active older women who depended on their children for financial, material and psychological care.

Sub-standard housing created a similar dependency that was a cause of dissatisfaction and worry. As in many developing countries, a woman’s access to housing was through men (Wells, 2005) and beyond their control to change. Some respondents described the impact poor housing conditions had on an already heavy workload. Emily was deserted by her husband and was relying on support from her natal family for her housing. She was in a tenuous position, the object of abuse and threats, and she had limited resources in her own right to take action to improve her living conditions.

Although many women were highly critical of their marriages, several respondents were trying to cope with the death or desertion of their husband. The social ramifications were extensive, as Trudi explained:

We think back to how her husband treated us all when he was alive. The death of a husband is a big problem. Its big, a lot of worry is caused by it.

Despite complaining bitterly about the lack of support they received from their husbands, women reflected on the social security they experienced in marriage and in having a husband to represent the family in public. Being an adult woman alone was difficult and unmarried and widowed women spoke of being the target of gossip and shunned by married women. A woman without a husband was closely monitored as a potential threat by other women. An innocent glance, let alone a conversation with a married man, could spark an altercation, threats and at worse, a physical attack against a woman by the man’s wife. This treatment provided an extra burden of anxiety and concern for widowed, single mothers or women deserted by their husbands.

### **6.3.3 “Because I worry so much I have permanent pains in my body”: Physical expressions of distress**

The physical health problems women highlighted were discussed in terms of the worry and concern they felt about their inability to change the conditions of their lives. Women mentioned a variety of physical complaints caused by worry, including loss of appetite, tiredness and inability to relax or sleep. Constant worry and a build

up of anger and frustration was associated with more serious physical illness such as dizziness, headaches, fever, and a head, which was heavy and solid “like a stone” and that prevented a woman thinking clearly. Thinking too much could make a woman vomit, and in some cases, result in severe stomach pain or cause her to faint – symptoms that were predominantly psychosomatic. Women’s heavy and relentless workload burden was also directly associated with chronic physical aches and pains, physical exhaustion and general weakness. Some women also experienced severe violence-related trauma. During a photo narrative exercise Sandy reflected on the life of a woman who was sitting underneath her house with her husband and children in one of the photos. She said the woman looked unhappy and worried. When asked why she might be worried Sandy began to describe the physical injuries she had sustained in the past from her violent husband:

I had just given birth and my husband kicked me in my side. The side of my body now is constantly painful. The problem is now I can’t lift heavy things, such as sago, yams or a heavy bilum. I can no longer carry them because I find it too painful.

It was common for respondents to suggest if a woman worried too much, the worry could cause serious illness, or in the extreme, cause a woman’s death. Many women’s narrative show “dying of worry” was a very real and inevitable consequence of repeatedly thinking about a problem. Kate, an adult respondent, reflected on the causal relationship of constant worry and serious physical complaints. She did not see worry as an illness per se but it was recognized as a major health problem:

Sometimes I am worried, I think too much about things and the worry makes me sick. Like malaria, even though we look after our health, mosquitoes bite us and we get sick. But there is another side to illness, and that’s worrying. If I worry too much, worry can make me sick too. So because of that I make sure I don’t worry too much. If I am worried today, tomorrow my worry will have finished. If you worry too much, for many weeks, or five days, one week or two weeks, then sometimes you will



become sick. If you worry too much it will kill you. Some days these thoughts come, worry comes, but the next day you need to have good thoughts again. You get up and just go to do the work yourself. You have to forget your worries.

Worry associated with disharmony or disputes within a family could also lead to an acute physical disorder. Respondents suggested unresolved disputes between a man and his pregnant wife, or between a man and his wife's family, could result in serious complications during child birth, such as protracted labour, foetal distress and quite possibly, as June explained, infant or maternal mortality:

If a woman has been worrying a lot and she is pregnant, the child will also be affected by this worry. If the mother is worried, the child will also have this worry. Sometimes we mothers, we face many complications during childbirth. And the child too won't be healthy once it is born. The child will be born with worry. And the child might not survive. Or sometimes the mother will die and the child will survive. We face many difficulties because of this.

Suicide was discussed as a permanent solution to women's worries and distress. Suicide has been discussed as a mode of social resistance adopted by women of many cultures because their rights have been neglected, they face chronic partner abuse (Douki et al, 2003) and lack an effective and more direct means of affecting the behaviour of others (Counts, 1980). Niaz (2003) suggests women are often so suppressed that instead of fighting for their rights, suicide is seen as a way out of economic deprivation and chronic hardship.

Many women in this study discussed their strategies to cope with the material and social constraints in their daily lives. However, many of the changes women desired - a reduction in school fees, a more communicative and less violent husband, supportive in-laws, better access to family planning, improved land use and resource sustainability and a decrease in the cost of consumables - required improvements in the social, economic and cultural structures that governed women's lives and the renegotiation of social relationships. Many of these changes were beyond a woman's

control. Women were positioned in a set of social relations they could not change by direct action. Constant forms of distress associated with these constraints and an inability to escape from persistent pressures led some women to consider suicide:

Sandra: You will feel like you want to die. I will kill myself.  
Hang myself from a tree. Some women drink medicine and commit suicide.

Tracy: I get angry with my husband and then I experience many problems. My head will ache, when I see him I think, forget it, I will just go and get medicine and kill myself. I get these kinds of thoughts. It’s because of my husband’s bad attitude.

#### **6.4 Discussion**

There has been limited examination of the psychosocial health of Papua New Guinean women and the perceived links to the social and material circumstances of their lives. The results of this study suggest that women’s health problems were related to the constant struggle of their daily circumstances, which included unequal social relationships, economic constraints, workload demands and regular abuse and violence. Women’s idioms of distress - “wari” and “tingting planti”- were a response to circumstances where life was a constant anxiety and a struggle with psychological strains. Women expressed their vulnerability to the conditions of their lives in a variety of ways and many women felt they had high levels of distress.

The emotional problems and worry seen in adult women’s accounts of their health were already emerging in young women’s narratives. Young women were exposed to factors, such as personal, financial and relationship stress, which affected their self-esteem, confidence and acceptance by their peers. Young women attempted to direct their life in ways that would improve their control over life chances. Consistent with the findings of Barahmand’s (2008) study of adolescent worry, these life chances, such as to have the opportunity to complete their education or to meet their social, economic and material needs, were associated with feelings of wellbeing in young women.

International literature suggests women's accounts of their health highlight the social and cultural roots of their problems and reflect the powerlessness and contradictions women encounter (Avotri and Walters, 1999; Hidebrandt and Kelber, 2005). The women in this study were expected to meet inflexible social reproduction and production obligations despite the unsupportive and unpredictable nature of their personal lives. Literature, discourse and evidence suggests that although people are very aware of the material context of their worry and concerns they often have no power to shape their circumstances or to effect structural change (Avotri and Walters, 1999; Hidebrandt and Kelber, 2005; Pietilä and Rytönen, 2008).

Although many women conveyed a sense of determination, strength and displayed resilience to cope with adversity, this study exposes the "weathering" of women (Shulz and Lempert, 2004) as a serious problem. Women were physically and psychologically distressed by constant exposure to, and efforts to mitigate, life circumstances in which there were many overwhelming social, cultural and structural challenges, as well as limited access to resources. Scaglione and Norman's (2000) analysis of resistance and agency amongst the Abalam, shows in circumstances where resistance has little effect, people simply withdraw, achieving strength through avoidance. For some women this meant it was easier to be submissive, take on additional economic and social responsibilities and ignore the threat of a violent husband.

Women's accounts showed they lacked the confidence to feel things would work out well and they had limited opportunities to shape their own destiny. This study documents, at an extreme level, women who spoke about suicide as a resolution for their struggles were experiencing an alarming sense of powerlessness in their daily lives and were severely constrained in their ability to change their circumstances by direct action. Suicide therefore was seen as way for women to communicate in a medium that they knew could not be ignored (Counts, 1980). A woman's suicide has been described in the Highland and coastal areas of Papua New Guinea (Ayers Counts and Counts, 2004; Counts, 1980; Wardlow, 2006) as a social and political act, an expression of power and agency by the powerless against adverse social relationships.

Violence is a serious form of discrimination against women in Papua New Guinea and women who experience violence are less able to realise a multitude of related rights, including the right to health, education, employment and decision-making. In many parts of Papua New Guinea, including the Wosera, economic deprivation due to lack of land and property rights, patterns of out-marriage and social isolation (Lewis et al, 2008) make more women dependent on men for economic survival, reinforce expectations of male authority and increase women's exposure to male violence (AusAID, 2008).

Evidence shows prolonged exposure to psychological and emotional demands have the potential to cause physical illness, in addition to mental illness (Marmot, 2006; Pietilä and Rytönen, 2008, Wells, 2005). The women in this study discussed psycho-physiological disorders, such as body pain, headaches and dizziness as symptomatic responses to long-term violence, personal suppression and subjugation of their feelings, that is their anger, frustration, fear and unhappiness. This is what Hou and colleagues (2005) have documented as an accumulation of traumatic stress. Physical health in itself was given low priority and only discussed in terms of the burden of a heavy workload, the lack of support received from men in production and social reproduction, violence and financial and material constraints. The emotional, mental and physical toll of women's day to day challenges requires immediate scrutiny. I argue, however, that it is not enough to acknowledge the powerlessness, helplessness and hopelessness of women's lives. Immediate steps must be developed and implemented to address the inherent inequities in women's health.

#### **6.4.1 Conclusion**

The high maternal mortality rate and the violence and discrimination women experience in PNG are all pressing issues that have informed public debates. However, the social, cultural and economic determinants of these problems and the physical and psychological impact on women's health are not consistently scrutinized, or reflected in public and health policy. The government of PNG has not taken much needed action against violence, particularly violence against women, which remains tacitly accepted in communities.

In Papua New Guinea there is very little data available on the mental health and psychosocial wellbeing of the population. Mental health service coverage is low (Gillet, 1990; Macintyre, n.d) and limited to acute clinical care. The National Department of Health (2000) recognizes community mental health care receives little attention. Staff training is lacking, the patient referral system is weak and public awareness and community involvement is minimal. This study reiterates Gillet's (1990) call over two decades ago for an immediate investigation into the impact of mental health disorders, particularly among women, and the development of a comprehensive and relevant plan of action. A review and update of existing policies and mental health guidelines such as the Public Health (Mental Disorders) Regulation also requires immediate attention for its relevance to the lives of women in Papua New Guinea.

Improvements in the health of women in Papua New Guinea will only be achieved with sustained political commitment to public policies and a multi-sectoral effort at the individual, community and organisational level. I support Lewis et al's (2008) call for a structural approach to empower women and to examine existing gender norms in the Papua New Guinean context. Material investment is required in programmes to address the links between the low status and material deprivation of women, violence and women's poor physical and psychosocial health.

A closer investigation of women's lives, psychosocial issues and workload burden is required to situate interventions to improve women's health within the context of their lives. A transformation of current policies and standards of women's health aligned with safe motherhood and reproductive health and an expansion of services in the area of psychosocial support is urgently needed to draw much needed attention to the identified needs and strengths of women, and for the recognition of psychosocial health and wellbeing as an area of concern. I hope through the weaving together of women's voices in this research, there will be knowledge translation and consciousness-raising between researchers and participants which will contribute to national debate on health and inform health policy and practice.

## **6.5 Summary**

Women experience powerlessness and helplessness to change the conditions of their lives. This can contribute to poor psychosocial health indicators, including depression, anger, frustration and, as the narratives of some women convey, the contemplation of suicide. The ability of women to cope with their challenging circumstances is dependent on their access to health protecting resources, discussed further in Chapter 7.

# CHAPTER SEVEN

## Publication 5

Accepted for publication in *Qualitative Health Research*

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### Stressors, Coping and Social Support among Women in Papua New Guinea

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Dr Jaya Earnest, contributed to the outline, provision of relevant references and the review of drafts, for publications undertaken with Rachael Hinton.

This paper has been peer reviewed, revised and accepted for publication. A copy of the published paper is included in Appendix 4.

## **7.0 Introduction to chapter**

This chapter explores the coping strategies women use in response to significant psychological stressors and personal adversity. Poverty, gender constraints and low social status challenge a woman's ability to maintain emotional and mental health and wellbeing. This chapter affirms that enhancing women's access to social support and control over social, economic and material resources will reduce vulnerability to risk and strengthen women's capacity to deal with challenging life circumstances.

As a note, the references used in this chapter to discuss the relationship between social and economic wellbeing and physical health are introduced early in the thesis in the introductory Chapter (page 18 to 21). They are also examined as part of Chapter 8. The links between psychological health and physical health, are referred to early in the findings Chapters (particularly Chapter 5 and 6) but the point is made explicit in this chapter and discussed further in Chapter 8 in order to draw conclusions and make recommendations. Please refer to Chapter 1 and 8 for further detail on the idea of coping as it is related to the literature on resilience. Examples and further discussion on coping strategies are also provided in Chapter 8.

## **7.1 Abstract**

An interpretive, ethnographic, qualitative approach is used to examine Papua New Guinean women's narratives and perceptions about their health and the ways in which these were linked to coping with personal adversity. Women used a variety of strategies to cope with psychosocial stressors and challenging life circumstances, including both reliance on their own agency and active efforts and the seeking of social and spiritual support. Limited access to social and economic resources, combined with gender constraints, made women socially and culturally vulnerable to social strain that affected their physical and emotional health. A number of women used avoidance strategies that were related to lower levels of self-esteem and life satisfaction and displayed high levels of anxiety. The need to understand the context in which coping takes place is proposed and to enhance resilience strategies used by women in developing countries such as Papua New Guinea to manage the multiple stressors associated with confronting life's challenges.



## **7.2 Introduction**

A body of evidence is now emerging that shows that social support in private life and social interaction in wider social networks contribute to a person's coping ability and is beneficial to health, whereas social isolation leads to ill-health (Cattell, 2001; Leipert & Reutter, 2005; Schulz & Lempert, 2004; Shaw, Dorling & Smith, 2006). Social support and integration in social networks provides opportunities for influence, social engagement, and access to resources and material goods (Berkman & Melchior, 2006). Access to these social resources has been shown to be less prevalent among individuals with low socioeconomic status (Kristenson, 2006; Polakoff & Gregory, 2002; Walters & Charles, 1997). In assessing the impact of support on health, it is important to recognize relationships can be either positive, and intimate, nurturing and supportive, or negative, and conflicted, demeaning and hostile (Berkman & Melchior, 2006). There is evidence to suggest that these negative aspects of relationships can have a very powerful and damaging effect on ill-health, perhaps even greater than the health-promoting aspects (Karlsen, Idsoe, Hanestad, Murberg, & Bru, 2004; Stansfeld, 2006).

The relationship between access to social, cultural and emotional resources, and women's health and vulnerability to risk has been examined previously (Leipert & Reutter, 2005; Moss, 2002) and social barriers identified that leave women in unsupportive environments, struggling alone. Women who live in poverty have few choices about where and to whom they might turn to for support, advice, information and assistance. Women who are more isolated, with restricted options and limited control over resources tend to have greater health risks and less ability to deal with risks (Leipert & Reutter, 2005). Multiple-role demands on women in most developing countries and rural economies leave little time for building community networks and social contacts. Social support can help reduce the sense of dealing with life's challenges alone (Polakff & Gregory, 2006). Inequity and deprivation have damaging effects on health, and isolation is seen as a compounding factor which can make it worse (Cattell, 2001).

Widespread gender inequity leaves women and girls particularly vulnerable to abuse, exploitation and violence in Papua New Guinea. Violence against women is

characterised by domestic and family violence, rape and gang rape, and the torture and murder of women suspected of sorcery (Amnesty International, 2006; AusAID, 2008a; Garap, 2004; Toft, 1986). Early marriage, repeated childbearing and heavy manual labour all have an impact on the health of women and their families (Gillet, 1990; Groos & Garner, 1998). Family and kinship are fundamentally important in Papua New Guinea. Eighty five percent of the population is rural and people tend to live in villages with close relatives. Men in Papua New Guinea do not usually participate in household agricultural production or childcare, as these are considered to be women's tasks. Polygamy is prevalent and fuels violence in communities (Haley, 2008; Toft, 1986). The practice of bridewealth (otherwise known as brideprice), a customary practice to unite two families and respective clans in enduring relations of obligation, is often construed to signify ownership and to legitimise a man's "right" to physically punish his wife when she is not performing her duties, or to demand certain services not included in traditional obligations (Macintyre, 2000; n.d; Toft, 1986; Wardlow, 2006).

Women advocates in Papua New Guinea and wider Melanesia (Jolly, 2000) increasingly argue that these practices are oppressive and reinforce widespread expectations of patriarchal dominance and male control over women (AusAID, 2008a; Macintyre, n.d). Customary patrilineal inheritance practices deny women land rights and unstable marital and familial relations restricts women's access to resources. This creates a level of economic dependence and vulnerability that contributes directly to women's inability to assert control over their lives (Freedman, 1999) and has been shown to contribute to the increase in HIV/AIDS among women (Gupta, 2002; Hammar, 2008). In Papua New Guinea the political landscape is dominated by men and fewer than 2% of the candidates in any of the national elections have been women.

Poverty confronts people globally with a multitude of psychosocial and material challenges linked to social status, isolation and lack of control over life circumstances. Such stressors challenge an individual's ability to maintain emotional wellbeing and can lead to poor psychosocial and mental health outcomes. Resilience to stress associated with low socioeconomic status is a contributing factor for health disparities. An individual's perception and attitude toward stress exposure is

dependent on their social status (Kristenson, 2006). People who are marginalized and impoverished are more vulnerable, tend to have more negative exposure, and less resilience and protective resources. People who have more resources in terms of knowledge, money, power, prestige and interpersonal resources such as coping strategies, social networks and social support are better able to avoid risk and able to adopt protective strategies when necessary (Link & Phelan, 1995; Solar & Irwin, 2007). Thus, no matter what the current profile of diseases and known risks happen to be, those who are best positioned with regard to important social and economic resources will be less afflicted by disease and psychological problems (Shaw, Dorling & Smith, 2006).

People can apply a number of different coping mechanisms such as problem-focused (task-oriented and approach) and emotion-focused (emotional approach as well as avoidant) strategies to deal with life challenges. An individual's choice of coping modality is dependent on the situation, with usually more than one strategy being applied over time (Kafanelis, Kostanski, Komesaroff & Stojanovska, 2009). Coping is associated with feelings of having control over one's life, power and optimism, the expectancy of a positive outcome, and seeing stressors as a challenge, not a threat. As stressors occur, depending on one's view of the impending threat and the resources at their disposal to handle the threat, a person might or might not be overwhelmed (Utsey, Ponterotto, Reynolds & Cancelli, 2000). As noted by Kristenson (2006), because the available resources are unequal in distribution, people higher up the social hierarchy have greater levels of coping ability. Personal psychosocial resources, particularly a person's capacity and agency to cope with and feel control over life circumstances, are important mediators of health. The inability to cope leads to leads to strain, frustration, and finally, helplessness and hopelessness. However, there is little research examining coping strategies used by women in resource poor countries to manage the stress associated with confronting life's challenges.

The aim of this chapter is to describe the factors that contribute to variation in rural Papua New Guinea women's psychosocial adaptation to adversity, in particular their ability to cope with and to develop strategies to manage experiences associated with poverty, inequity and a lack of resources. I drew on women's voices and narratives to

understand the ways in which life challenges affected their health and wellbeing. The women shared ways in which they accessed resources necessary to build agency and protect health. The strategies women used to meet these challenges and maintain their health were explored.

### **7.3 Coping among rural women in PNG**

In the following discussion we examine the different ways women dealt with daily challenges and psychosocial stressors throughout the lifespan. We examine women's specific coping responses, personal psychosocial resources and access to social support in light of the realities of women's lives. Participants cited economic constraints, heavy workload demands, and unsupportive relationships as their main stressors. Limited access to social and economic resources, combined with gender constraints, made women socially and culturally vulnerable to social strain that affected their physical and emotional health.

#### **7.3.1 Coping with economic constraints**

Confronted with difficult life conditions, the women in this study tried new strategies and enhanced existing strategies to maintain their health and wellbeing. The most common theme to emerge in discussions of women's coping strategies was to be self-reliant and confident in their own abilities to meet economic demands and provide for their family. Sally's self-esteem and sense of security in her own capacity to earn an income and to meet the daily subsistence needs of her family contributed to the strengthening of her mental and physical health.

If you are a woman and you don't work in your garden and you only look to your husband to provide, you will worry, feel sorry. If you are a woman who works in the garden, or you go to the market to earn money then you won't feel worried or sorry. Then you will be healthy. For example, your house will have enough food.

Single and married women could rely on their immediate family, in particular their "blood relatives" - mother, sisters and brothers - for financial support. A very small number of adult women expected their husband to be the main economic provider of

the household. However, most respondents portrayed a coping style that was based more on self-reliance than dependence on others. Women would often take it on themselves to tackle their own problems without expecting or seeking the help of others (Hattar-Pollara, Meleis & Nagib, 2003). This was a prevailing theme for women's coping patterns. The most common statement heard was "*mi meri blong makei*" (I am a woman who [sells produce at] markets), and underlying this was a sense of their own self-reliance and independence, as the following quote from a young woman conveys. "If I go to the market, I will be able to look after myself. Otherwise, where will I get money for food, soap, and kerosene?"

Trudi admitted that to find money to meet material needs a woman had to "work hard. If you work hard to make a garden, harvest the food and sell it and make some money, then you will survive." A constant worry in all women's lives was the economic burden of meeting domestic and social obligations. Women reduced this worry and anxiety by using their initiative and by being resilient to stressful encounters as they unfolded. They sold garden produce (bananas, coconut, peanuts, sweet potato, corn and betel nut) cooked food (doughnuts, smoked fish) or other small items (cigarettes, candy) at local markets to meet domestic and household costs. It was the main source of income for the majority of participants and many women planned ahead, planting crops specifically for sale. A small number of women looked to meet gaps in the market by selling second hand clothes, purchased in a bale from Wewak, the provincial capital, or by sewing clothes for sale. A significant initial outlay was required to purchase a sewing machine (AUD\$150) or second hand bale (AUD\$200-AUD\$300). Unless the amount could be borrowed from family members, it was not an affordable alternative. For some participants, the harvest and sale of cash crops, such as cocoa and vanilla, offered an additional means of income. During the study period the price of vanilla had dropped from PGK600 (AUD\$400) per kilo to PGK8 (AUD\$5.00), and cocoa was reaching bringing between PGK1600 and PGK2000 per ton, around PGK1.60 and PGK2 (AUD\$1.00-AUD\$1.30) per kilo. Women sold vanilla or cocoa as a supplement to market sales and on a needs only basis. This could raise between PGK5 to PGK20 (US\$3.00-AUD\$13.00) per sale.

An adult participant explained that a woman would experience frustration and resentment if she depended entirely on the will and cooperation of others to meet her needs. A reliance on relationship dependence would result in arguments, instability and ultimately a poor sense of wellbeing. Women valued their role as “the glue that kept the family together.” Their own worth was enhanced if their productive capabilities contributed to meeting familial and communal obligations. However, participants were very aware of and were vocal about the unjust division of labour. A woman who did not work hard to provide material and financial support for the household, as well as share resources with the wider community was seen to be deficient in her role as wife and mother. Women faced strong societal expectations to fill a compliant and subordinate female role (Dageid & Duckert, 2008), and directly going against patrilineal structures was difficult. “Inventive copers,” as described by Kafanelis and colleagues (2009), are aware that life circumstances have become confounding factors in their current experience and in response adapt to changing situations and environments. The women in this study reflected on the cultural prescriptions of their role and did what they could to mediate and mitigate the negative effects. As Anita explained:

If you wait for your husband to give you money you will be frustrated and angry. You won't have money to buy kerosene or to buy soap to wash your clothes. When others see you, you will look dirty.

A dependence on personal psychosocial resources was intrinsic to all accounts across the life span. Young, adult and older women expressed the importance of self-reliance and the ability to make the best of available options and resources to gain some control over life circumstances. Barbara could rely on a variety of options for raising an income and compared with other respondents she conveyed less anxiety associated with meeting her daily needs.

I sell second hand clothes, I sew clothes and my mother also gives me money that she earns from selling food at the market. I have plenty of work on the side so I don't worry about money.

A strategy several adult women used to alleviate their financial concerns was to budget and save for future expenditure, such as school fees or brideprice contributions. A widowed adult woman discussed her strategy for raising the brideprice for her son's impending marriage, a cost of around PGK1000 (AUD\$660). Reciprocity and the sharing of resources and wealth to support the aspirations and obligations of the kin group and clan is a significant cultural practice and obligation in Papua New Guinean societies. She relayed how during the past few years she had financially contributed to many family and community customary and social activities, and it was now time for her to call in her debts. She had found this to be a risky strategy as by investing in customary relationships rather than saving the money herself, she had pinned her hopes on people fulfilling their social obligations to reciprocate. At the time of the study she was extremely worried that her contributions would not be fully reciprocated. Without a husband to negotiate additional repayments, she believed she would be unable to meet the cost of the brideprice.

With access to money, women were in a better position to access to psychosocial resources necessary to protect health. Women conveyed that they felt less anxious, insecure and isolated and that they had some degree of control over the conditions of their lives. A woman could fulfil some of her more pressing domestic and familial obligations. She was able to purchase fresh produce, protein such as tinned fish and smoked fish, and other household necessities. Some young women placed high hopes in the freedom money would give them to “*go raun long taun or wanem hap mipela laik go*” (go to town or wherever we want to go). For young women still in school it would allow them to complete their education and assure them a more certain future. This future involved significant improvement in access to social and economic opportunities outside of the village.

Money also gave women access to a wider social network. Women had a purpose to go to the market and socialise with others. The weekly market was a significant social activity and an opportunity to meet with friends and family. Most days a heavy household workload and childcare duties prevented women meeting friends and family. It was therefore both isolating and frustrating for young and adult women to remain at home on a market day.

Women experienced an enormous burden to source funds for household necessities, children's school fees and associated costs, and to meet cultural obligations and contributions. Women utilised different modalities of coping and accessed a variety of resources to manage challenging circumstances (Kafanelis et al., 2009). Women's objective for coping was to get their problems under control through directive efforts and the social support system (Ching, Martinson & Wong, 2009). Pamela asserted that:

Everything needs money. On the physical side, like food, we can do the work ourselves and the food can grow and we can eat. Everything from the store and other big things such as brideprice and school fees need money.

### **7.3.2 Coping with unsupportive relationships**

Social relationships are not necessarily supportive and can sometimes become a stressor. When social relationships are experienced as negative, it affects a person's ability to cope (Karlsen et al., 2004). Many women in this study discussed experiencing unsupportive marital relationships, represented by a lack of emotional, social and economic stability. Women experienced a heavy and unequal workload burden and were typically responsible for domestic production and all childrearing activities. Women were resolute that this burden was a direct result of being female. The relationship between a woman's heavy workload and an unsupportive husband or parents, emerged as a common theme. Respondents talked at length about their attempts to deal with unsupportive relationships. Women's main coping strategies included problem-solving and seeking social support, although some women described their reliance on passive-emotion-focused coping, such as denial, resignation and mental disengagement.

The majority of women used task-orientated coping styles to deal with unsupportive relationships and manage economic and workload stressors. Most women could access material resources, such as land and markets, and turn to social resources for instrumental (assistance with funds or workload demands) and emotional reasons (someone to talk to). They planned and were systematic in their approach to meeting their workload and economic needs. However, multiple workload demands put many



women at increased risk of psychological burnout, which could impinge on their ability to adapt to stressors in the long-term (Karlsen & Bru, 2002). The choice of active, problem-focused coping strategies aimed at altering life circumstances available to many Western women (education, employment opportunities, welfare) were limited for the women in this study. With restricted options to change their situation, the consistent use of problem-solving and task-oriented strategies could result in distress, arguably more than emotion-focused efforts, such as avoidance and denial (Dageid & Duckert, 2008). Women expressed resignation, frustration and anger about the constant pressure of their role and the heavy burden of meeting their responsibilities in an unsupportive environment. “Some times you can make a joke about how you feel or you can get angry. When you get cross and you let it out then you will feel your anger go down.”

Several respondents discussed “giving up,” or “just trying to forget” as a way to cope with an unsupportive relationships and marital conflict. Many respondents chose at times to cover up how they felt about their heavy workload burden and discord in their relationships. They described their hurt, anger, resentment, frustration and despair and the ways in which they kept their feelings to themselves to avoid a fight and maintain their self-respect. They described using strategies to help them endure the constant worry, to not complain and accept their circumstances, knowing there were no better alternatives (Hattar-Pollara et al., 2003). “I keep my problems to myself. I just ignore my husband. I eat and then I just go to sleep.” “When I am really worried and think a lot I cry. So I pray, that’s the one way I know, that God will give good thoughts to my family so they will treat me better.” Other women tried to address hostile relationships by withdrawing and “going on strike.” This could range from a woman refusing to talk to her husband to leaving him for several days in charge of the household. As Alice explained:

Some women will sit down and not say a word. They won’t say a single word. Then you will realise that she is angry. Some women have this kind of attitude. This is the way they will show you they are cross with you.

Young women described withdrawing entirely and running away was a strategy used to deal with parental neglect or marital abuse. Leaving the marital or parental home

was an extreme measure that indicated a high level of stress and discord that could no longer be tolerated. For many women it was a means of self-preservation. Some married women could seek refuge in the home of their biological kin to engage broad support and have the dispute mediated on their behalf. These methods provided women short term emotional relief but were inadequate for the long term. Esther explained:

I don't feel good. It is his bad attitude and behaviour that makes me leave him. I go on strike for one or two weeks. I won't give him food. I will walk around aimlessly. I will come here [to the house of my cousin] to eat, or to my parent's house.

Several women experienced chronic violence in their marriages and preferred avoidance coping in response. Confrontations had become so costly in terms of time and energy that withdrawal or acquiescence had become a practical and safer option. These women felt powerless to modify or improve their situation. They did not have the familial support or opportunity to leave violent relationships permanently and they responded to their mistreatment with extreme passivity or by contemplating suicide.

Ellen: My head hurts. When I see my husband I say to myself, forget it, I'm just going to get some medicine and kill myself. I get these kinds of thoughts, because of my husband.

Fran: Sometimes if a man leaves his wife for another woman, his wife won't be able to think straight. Her heart is broken. You will feel like you want to die. I will kill myself. I will hang myself from a tree. Some women overdose to commit suicide.

Individuals who use avoiding coping strategies, such as distraction or daydreaming and are unsuccessful in dealing with their stress, can develop symptoms of depression (Welch & Austin, 2000). Several women in this study recalled severe signs of anxiety which included fainting, sleeplessness and inability to concentrate. Some respondents felt inadequate and powerless to deal with their marital

relationship in a problem-solving manner. The respondent in the first quote displayed a significant level of resignation about her situation.

Sarah: How will I fix it? It's not as if he is a small child. How will I fix the problem because he smokes marijuana as well?

Pamela: It's our problems that cause us to walk around like a sick woman. You won't look smart or you won't be active. People will see you and ask if you are sick. And you will lie and say, yes, I'm sick. But it is worry.

Several young adult women described worrying signs of anxiety related to their inability to deal with marital discord. One participant recalled the times she had collapsed because of the extreme worry and anxiety she felt about her marriage. Her co-respondents saw her hopeless state as extremely damaging for health. "Her husband is there but he doesn't help her with anything. She finds it hard to think straight. She gets confused and feels dizzy and she collapses." As has been described in the literature elsewhere (Dageid & Duckert, 2008), respondents' discussions showed clear links between psychological and physical morbidity. In the extreme, severe distress could result in a woman's death as Kate explained.

If I think too much about my problems or when I work and I worry at the same time, I think that my worry can kill me. So I try not to work too hard, think too much or argue with my husband. I just keep it to myself.

Strong negative feelings and distress were considered contrary to women's attempts to persevere in difficult conditions and to maintain a good sense of individual and family health and wellbeing.

Freida: We aren't happy, we feel worried. Sometimes when we are worried we have headaches. And because of this we get confused and we have a lot of negative thoughts and so we take it out on our children. We chase them, tell them off for no reason, we get angry. This happens to us as mothers. We face a lot of problems.

Kate: Sometimes I am worried. I think too much about things and the worry makes me sick. If I worry too much, worry can make me sick too. So because of that I make sure that I don't worry too much. If I am worried today, by tomorrow my worry will have finished. If I worry too much, for many weeks, or five days, one week or two weeks, then sometimes you will become sick. If you worry, you know that, if you worry too much it will kill you. Some days these thoughts come, worry comes, but the next day we will have good thoughts again. We get up and we go and do the work ourselves. We have to forget our worries.

### **7.3.3 Seeking social support**

Social support is an important resource that has been shown to have a positive impact on wellbeing and reduce the negative effects of stress (Karlsen et al., 2004; Nazroo & Williams, 2006). Social support has a protective effect by decreasing or preventing the risk of illness (Stansfeld, 2006) and has been associated with high rates of disease-related coping (Curtis, Groarke, Coughlan & Gsel, 2004). The women in this study recognized that family support and positive family interactions, with one's husband, in-laws and kin group, were invaluable for helping women cope with psychosocial stressors. The effect of social ties and support networks on women's health was dependent on a variety of demographic and contextual factors, including age, village of origin, marital status, access to land and position within the household.

Women who experienced supportive family interactions and could access support from friends had the opportunity to talk and think about how best to handle a problem. Social support had a buffering effect, which helped to moderate and mitigate the impact of acute and chronic stressors on health (Stansfeld, 2006). A lack of support, which was the result of social isolation and spousal or familial restrictions, had a direct impact on women's health. Women with limited social support expressed their hopelessness and helplessness to manage or avoid psychosocial stressors. They had low self-worth and a poor sense of wellbeing.

Tracy: When I sit down with my sister in-laws and my husband's brothers, they don't talk in front of me. They talk behind my back. My head feels heavy because of this. I don't talk to them. I don't feel happy.

Sally: When I work I feel worried. I'm not from this village. I wanted to get married and I came here. But I don't have sisters here, or brothers to help me. Who will help me as I'm not from here?

The parents of a young adult woman had died and because of her restricted social support network, she found it difficult to cope with the changing conditions of her life.

Tania: I look at the girls my own age and they have their parents to look after them. Their parents help them in their gardens. Or their brothers help them. I don't have this kind of help. Every time when I have a lot to do, I continually think about my parents. This is what I think about the most.

For most adult respondents, religion was a source of personal comfort. It provided meaning and balance in women's lives and gave women a sense of control over difficult life circumstances. It was also a source of social and cultural connection and women were able to develop and enhance friendships with likeminded women. Respondents described how they depended on their spiritual beliefs for guidance and strength of will when dealing with personal and social hardship.

Religion provided a framework for women to think through their problems, and with which to measure or improve their own or their spouse's behaviour. It gave many women the strength to identify more active coping strategies, to boost self-esteem and promote positive self-appraisal. Although women's religious beliefs promoted strength and internal resources for coping, prayer was used by some women when nothing else could be done to alter or modify their conditions. During a focus group discussion an adult woman shared that prayer helped her to endure difficult times, but clearly the underlying stressor remained.

Julie: I pray and then I have better thoughts. Like, about my marriage. I have these problems. The father of my child didn't look after me so now I live with my brother, my mother. I think about these problems too much so I pray. I pray and God helps me. Good thoughts come to me.

#### **7.3.4 Sharing life experiences as a means of coping**

The women in this study sought social support for practical and emotional reasons. Most women said they could talk about their problems with either a family member or a close female friend. Women were given advice on ways to solve a problem and they received necessary support to boost their self-esteem and confidence. A trusted blood relative, a sister, aunt or grand parent, was identified as a common source of support, and for young women especially, friendship networks and close, personal relationships were seen to be beneficial to health.

Depending on the issue and the type of social support required - either practical, emotional or both - respondents evaluated the most suitable option for support. For example, a young woman related that she could talk to her brother and sister-in-law about arguments with her parents, but would only talk to her girlfriend about boyfriend-related issues. Many older women talked to their children and to trusted women of the same cohort who were experiencing the same disabilities and health problems. Other older women simply kept their problems to themselves, prohibited by their children to divulge their concerns to others because it would be seen to reflect badly on their family. Several older respondents mentioned that their only source of support was to pray to God for an imminent death.

Anne: I want God to do his thing so I can die. I want to see my relatives who have died. When I go to the garden I think about them and I cry.

Several adult women who had been neglected or abandoned by their husbands sought support in church networks, with “women of similar experience and needs.” These women struggled to acquire resources to support themselves and were solely responsible for their family's sustenance. They therefore helped each other with workload obligations and could be relied on for emotional support when they were the target of unwarranted gossip generally related to suspicion of an extra-marital

affair. These female friends were valued for their candid and genuine contribution to the social support experience.

### **7.3.5 Adverse effects on coping and seeking social support**

Various contextual (gender roles, financial constraints, production and childcare demands) and personal (self-esteem, adaptability, attachment to others, spiritual values) factors affected a woman's ability to access the resources necessary to protect and enhance health and had an impact on women's ability to cope. Women's access to income-generation opportunities were few and only one adult woman had the means with which to diversify outside of market sales. The women in this study were also restricted in the resources that they could draw on for support. A heavy workload, familial obligations and a husband's control over his wife's movements restricted a woman's ability to socialise and make social contacts. Husbands were seen as unsympathetic, a threat or the cause of their problems and health workers were rarely cited as a source of help or support. Because several participants had married outside of their village, distance played a part in restricting their access to natal kin and wider support networks.

The most common reason given for not seeking social support was embarrassment or shame. A frequent comment made by respondents was that problems inside the immediate family should stay within the family and as such women chose to "keep their problems to themselves." Women concealed their pain and internalised their problems. Consistent with the findings of Walters and Charles (1997), women were trapped by a coercion of privacy. They were expected to succeed and be seen to be managing in the role of wife and mother despite the difficulties faced in meeting often impossible demands. If a woman did talk to others about her problems, she left herself open to suspicion, people could "*tanim tok*" (to change what is said) and "*tok beksait*" (to talk behind a person's back). This could result in violent consequences.

A lack of anonymity and risks of breaches of confidentiality were therefore a major hindrance to women seeking social support. The respondents lived in a very small community in which most people were related, and as a result women were aware that "*toktok bai muv*" (what was said will be spread). Most respondents were hesitant to talk about their economic concerns with individuals outside the immediate family

in case it was misconstrued. If a woman was suspected of asking for money, she would be seen to “have no shame” or self-respect. Some respondents reflected that in some circumstances they could not even trust members of their own family. A young woman recalled that “I can ask for my sister-in-law’s (brother’s wife) advice, but I could never share my secrets,” because the information could be passed to her brother whose role it was to “discipline her” if she defied traditional customs. During a focus group discussion, a widowed adult woman admitted that she rarely looked to her two married sisters for support in case they suspected she was seeking the attention of their husbands. Her sister, who was also a participant, concurred with the comment.

#### **7.4 Discussion**

Numerous social, cultural and economic factors contributed to a woman’s psychosocial adaptation to different life challenges and her ability to develop strategies to cope in response. Comparing the findings of this study with the coping strategies of women in other non-Western settings (Ching et al., 2009; Dageid & Duckert, 2008), it has been shown that the coping process is highly context specific and related to a array of personal, cultural and social factors. Women’s choice of coping strategy was linked to the circumstances in which it was performed and the purpose for which it was intended.

There was also a resonance between the voices of the women in this study and the literature about women’s health, and health and poverty (Avotri & Walters, 1999; Hidebrandt & Kelber, 2005; Schulz & Lempert, 2004). Unsupportive and unequal relationships and increasing economic demands saw women turning to their own active efforts, to spiritual and social support, and the resources that could be mobilised within those networks, to maintain health (Schultz & Lempert, 2004). Women described their efforts to avert the hopelessness and uncertainty that some respondents described experiencing.

Although a woman’s health-related coping behaviour was to some extent within her control, many of the social determinants of health were not. A woman’s agency was constrained by the situations and statuses that were conferred on her (McDonald &



McIntyre, 2002). However, consistent with the Melanesian context described elsewhere (Stewart & Strathern, 2000; Wardlow, 2006), the women in this study had the confidence to take personal responsibility for improving their conditions, and showed strong signs of self-assertion, self-worth and independence in very trying circumstances. Respondents described a host of individual actions that enabled them to gain some control over their life. They relied on, but recognized the limits of, the resources that they could access to sustain themselves and their families.

The problem-solving and task-orientated strategies discussed by the women in this study appeared to have a positive outcome. These strategies present a pathway for the prevention of emotional distress and mental health problems among women. Studies in other parts of Papua New Guinea have shown that when women earn an income from their own labour they have more control over its allocation. The public recognition of their enhanced capacity to provide for their families also allows women to assert their independence and authority in support of the development of their families and communities (Koczberski, 2002). The development of livelihoods strategies and credit and savings schemes in the Wosera could build on the existing skills, knowledge and self-reliance of women, empowering them to tackle new challenges and increasing their self-esteem and capacity to care of themselves and their family. Positive intervention programs based on empowerment and which target the psychosocial determinants of health would give women and men the capacity to handle exposure to stressors, not as problems but as challenges that can be overcome.

Consistent with the wider coping literature, our study showed that emotion-focused and avoidance coping was detrimental to psychological wellbeing and contributed to poor health. Evidence shows a significant relationship between emotive coping and negative outcomes (Karlsen et al., 2004, Curtis et al., 2004). Avoidance strategies are related to lower levels of self-esteem and life satisfaction, high levels of anxiety, and consistently associated with poor social adaptation (Desmond & MacLachan, 2005). According to Reviere and colleagues (2007), women who experience intimate partner violence and have attempted suicide as a coping strategy are more likely to accommodate or placate their abuser, whereas other women report a greater tendency toward safety, self-preservation or try to identify ways to leave an abusive

relationship. These women also utilise other positive coping strategies, such as seeking social support.

The reasons for avoidance coping by the women in this study were not always expressed, but might reflect long standing coping patterns and the helplessness of women to deal with issues in a problem-solving manner (Welch & Austin, 2000). Participants shielded their emotions to avoid intensifying their oppression and they emotionally or physically removed themselves from unfavourable circumstances. Utsey et al., (2000) show in their study of the coping strategies used by African Americans to deal with racism that avoidance coping is preferred because a confrontational response can result in violent outcomes. It is therefore easier to withdraw and ignore the threat. The suppression of thoughts and emotions has been shown to be related to perseverance and endurance when confronted with trauma and adversity (Goodman, 2004).

Exploring the concept of resistance and agency amongst the Abalam, Scaglione and Norman (2000) reflect that in circumstances where resistance has little effect, people simply opt out, achieving determination through avoidance. Thus this type of strategy might reflect the social context as much as the needs of the individual. A thorough examination is required to ascertain whether avoidance coping is a form of resistance or is disempowering for women (Hattar-Pollara et al., 2003).

#### **7.4.1 A way forward**

The protective nature of social affiliations and social support for health has been well documented (Desmond & MacLachlan, 2006; Stansfeld, 2006; Wilkinson, 2006). Social support is central to women's health and affects women's ability to deal with risk and vulnerability. Physical and social isolation, limited options and the undervaluing of women increases the need for social support. People who perceive supportive family behaviour report the more frequent use of problem-focused coping styles. People with restricted networks are more likely to express feelings associated with negative health outcomes, such as anxiety and depression (Cattell, 2001). Poverty has a direct and negative influence on health, but isolation adds to the deterioration of health (Leipert & Reutter, 2005). Many women around the world, because of an array of social, cultural and economic factors, are vulnerable to poor

psychosocial health, unable to cultivate health-enhancing relationships or promote interpersonal connections (Karlsen & Bru, 2002; Moss, 2002; Niaz, 2003). The women in this study who had restricted social networks understandably found it more difficult to cope.

Preventive interventions and the provision of adequate support to improve women's coping strategies and resilience at various critical stages of the life cycle, where its lack could lead to depression, might help women deal with life transitions. Learning to cope well as a young adult with life's changes and challenges or, alternatively, learning helplessness and hopelessness, has a decisive influence on adult coping experiences and to feelings of control over life (Kristenson, 2006).

Women in Papua New Guinea are part of a nexus of social relationships – between spouses, siblings, parents, in-laws and others – and it is not surprising that this is the framework within which women's expressed their struggles and their modes of coping. Efforts to involve family members in a supportive manner could help young, adult and older women cope with psychosocial stressors and create a context of resilience. Health professionals should consider ways to educate family members and peers as sources of positive support for women and effectively utilise these resources when planning health care programs for women (Karlsen et al., 2004). This is an issue requiring more research and has strong participatory action research possibilities.

The small number of women in this study who relied on avoidance were at risk of, or might already have had the symptoms of depression. Depression and a low level of self-esteem is associated with psychosocial stressors, especially limited control over one's life (Welch & Austin, 2000). Because contextual factors have an immense impact on women's lives, they must also be taken into account in health care efforts (Dageid & Duckert, 2008). Health workers should assess for the symptoms of depression and be familiar with verbal and non-verbal behaviours that would indicate the use of avoidance coping. If women are struggling to cope with the demands of daily life, interventions must be aimed at getting women to talk about issues that are stressful for them. Health professionals must support individual women to reflect on their situation, allow them the freedom to examine their strengths and constraints and

develop the most appropriate coping strategy based on available resources. This is preferred over coercion and pressure to use measures which are seen to be adaptive (Ching et al., 2009; Reviere et al., 2007).

#### **7.4.2 Conclusion**

Very little attention has been given to understanding the contextual factors that influence women's coping mechanisms in Papua New Guinea in relation to their health and wellbeing. An examination of the stressors women are exposed to and that require them to use, what we have shown to be, a repertoire of coping strategies, is necessary for the development of effective interventions. This is specifically true in the light of how coping strategies are connected to a person's social circumstances, self-esteem and perception of quality of life. The women in this study resorted to a combination of problem-focused and emotion-focused coping when confronted with stressful encounters (Karlsen & Bru, 2002). Women's examination and interpretation of these stressors affected their use of coping strategies (Ching et al., 2009).

The women in this study dealt with their circumstances of deprivation, limited social support and chronic uncertainty with determination and strength, vital resilience qualities related to the health of women living in poverty (Polakoff & Gregory, 2002). Psychosocial capacity is a significant mediator of the severe effects of poverty and discrimination. However, because women are exposed to chronic stressors that reflect their socioeconomic circumstances, there can be no substitute for a more equitable distribution of resources (Cattell, 2001). Thus interventions aimed at enhancing coping strategies must be embedded in a broader strategy of structural change to create the opportunity for women to access the necessary resources to improve and gain control over their own lives (Kristenson, 2006). Government, civil society and other stakeholders must build on, learn from and systematically engage long term with local initiatives and organisations that are driving socioeconomic change and promoting social justice in their communities (such as *Lus Fruit Mama* in West New Britain, Kup Women for Peace in Simbu Province, Young Women's Christian Association [YWCA] in urban settlements). These organisations are working to address some of the core stressors that impact on women in Papua New Guinea, yet so far there has been no political commitment of action supported by funds to strengthen local efforts. Funding agencies, major donors and the legal and

education sector, in cooperation with relevant partners (non-government organisations, churches, private sector), must drive the process of policy and coordination at the national, sub-national and local levels that draws on the “voices” of rural women. There is a requirement to provide an environment conducive for change, based on self-reliance, the value of participation, equality and the use of local resources.

## **7.5 Summary**

This chapter has shown that the social and material conditions of women’s lives impacts on their ability to cope with personal adversity and constant psychosocial stressors throughout the life cycle. Personal resilience, social support and problem-focused coping contribute to enhanced self-esteem, feelings of control and life satisfaction among women. Strengthening access to these resources should form the basis to interventions that work to address the inequity, violence and multiple-role demands that women confront in their everyday lives.

## **CHAPTER EIGHT**

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# **DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS**

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### **8.0 Introduction**

This thesis has presented findings that are based on Papua New Guinean women's own narratives and personal understandings of their life circumstances. The objective of this study was to put rural women's experiences of health at the centre of health research and offer an alternative to the current biomedical focus of women's health in Papua New Guinea. The study has documented that women's health concerns the totality of women's experiences throughout the life span, with the implication that overall health includes, but is not defined by, reproductive health.

### **8.1 General discussion**

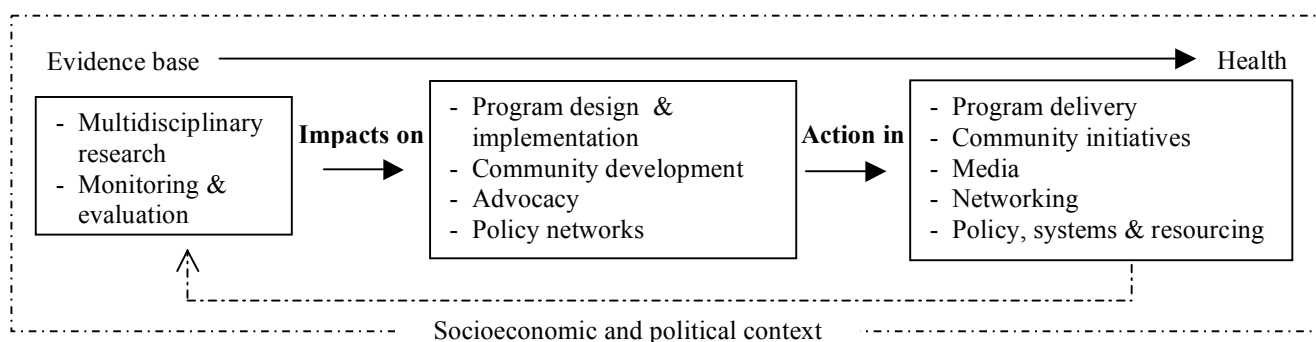
Despite a focus on maternal and child health by health workers, governments and international aid agencies over a considerable period of time, women's health remains a major international health problem. High maternal mortality rates cost the lives of 1,500 women each day globally, mainly women who live in developing countries (WHO, 2009). Women in sub-Saharan Africa have one in 16 chance of dying in pregnancy or childbirth, compared with one in 4000 risk in developing countries. This is the largest indicator between poor and rich countries of any health indicator (UNICEF, 2009a). Afghanistan has one of the highest rates of maternal mortality in the world and around 1800 Afghan women die out of 100,000 live births each year (UNICEF, 2009b). Women continue to live in conditions where they face gender-based inequalities, inequitable access to resources and constant economic pressures and constraints. Many lessons about a more inclusive and social approach to women's health have however been learnt in the past decades (Meleis, 2005; Ruzek, 1993). It is now recognized that women's health is interlinked with the circumstances of women's lives and has to be tackled with a combination of multi-

sectoral measures tailored to the local settings and contexts and the identified needs of women.

In recent years there has been an increasing body of knowledge about women, health and poverty (Awumbila, 2006; Hildebrandt & Kelber, 2005; Polakoff & Gregory, 2002; Schulz & Lempert, 2004) and the psychosocial determinants (social capital, coping strategies, stress and anxiety) of women's health (De Silva, Huttly, Harpham & Kenward, 2007; Wells, 2005), with a particular focus on the negative effects of gender inequality on women's health.

The challenge is to translate these new research results into the design and implementation of programs and advocacy efforts and for the development of policy networks. The results will be seen in locally appropriate services and programs for vulnerable women and increased awareness and sensitivity to the rights and needs of women. (Figure 4). Since the Alma Ata Declaration of 1978, the relevance of a holistic approach to women's health has been clearly recognized and reinforced in international declarations and frameworks, including the Beijing Platform for Action in 1995. The acknowledgement of the social, economic and cultural aspects of health has led to an increasing call to put women's experiences with discrimination, inequality and helplessness at the centre of women's health and as motivation for women's empowerment.

**Figure 5.** The translation and operationalization of research into practice



Women's health has been emphasized as a reproductive health issue in order to achieve demographic goals and to ensure the health of children (Avotri & Walters, 1999; Freedman, 1999; see Chapters 3 & 4). Women's bodies have been targeted as discrete biological systems and women are seen to be "free to choose" individual

health behaviours in order to avoid risk (Freedman, 1999). This is difficult in contexts such as Papua New Guinea where women are disadvantaged by discrimination that is rooted in socio-cultural context and which restricts women's ability to attain the best possible level of health. For example, economic marginalization and unequal power relationships between men and women in PNG contribute to women and girls facing increased vulnerability to HIV/AIDS.

This approach, strongly influenced by the Western biomedical framework, has determined much of the investigation into risk factors associated with disease and maternal mortality reported in international literature, and applications have been based on these findings. Population-based studies that support the relationship between specific social determinants or "risk" factors and health outcomes is a topic most frequently discussed.

A common theme of the thesis however is that women's own narratives reflect the multidimensional nature of women's health and that health cannot be decontextualised from women's relationships or the inequitable conditions of women's daily lives. Adapted from Moser's framework for the patterning of women's health, Table 5 presents an example of the multidimensional nature of women's health across the lifespan for women in resource poor settings such as rural Papua New Guinea. The health of women is neither static, nor based on women's biological and reproductive capacity alone.



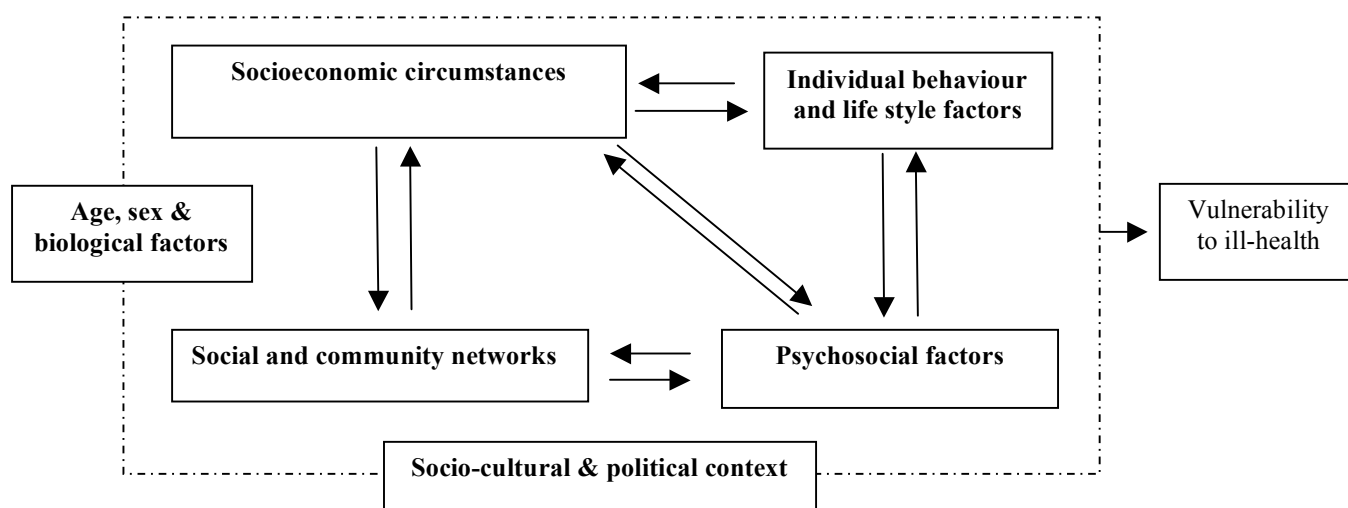
**Table 5.** The multidimensional nature of women’s health across the life span in rural Papua New Guinea

<b>Geopolitical environment</b>	<b>Culture, norms &amp; sanctions</b>	<b>Women’s roles in reproduction &amp; production in the household</b>	<b>Social networks &amp; social support</b>	<b>Mental &amp; psychological health</b>	<b>Behaviour</b>	<b>Physical</b>
<b>Geography</b> <b>Policy and services</b> Transport Health Welfare <b>Legal rights</b> Women Human Health Employment <b>Economic</b> Extent of inequality	<b>Discrimination</b> Ethnic Gender Age <b>Sociodemographic characteristics</b> Age Gender Ethnicity Birthplace Education Marital status Religion Language Spirituality	Division of labour Household structure Ownership of property Access to resources (income, land, food, housing, other assets) Community roles Labour market role Violence <b>Livelihoods</b> Sector Formal Home/market based Authority and decision making Discrimination	Friendship and peer groups Pre-marital inter-gender relationships Family cohesion Marital relationship Church Other social ties	Stress & anxiety Helplessness & hopelessness Mood Coping style Resilience Spirituality (traditional and Christian based) Self-esteem and confidence	Sexual Substance use Physical activity (associated with women’s roles) Diet Contraception Breastfeeding Smoking, drinking Communication and socialization	Acute and chronic disease Reproductive health Mortality Disability Mental health / illness

This thesis builds on the study of the social determinants of women’s health, and in the attempt to understand the multidimensional nature of women’s lives, it takes a more holistic approach than previous studies of women’s health in Papua New Guinea. Figure 5 expands on Table 5 and shows that the types of influences on women’s health are not only varied, but most factors interact with each other in complex ways to produce health outcomes. Some differences in health status are unavoidable, being the result of genetic and/or biological differences in individuals. However, many are avoidable, resulting from a complex interplay of factors including women’s personal strengths and vulnerabilities and their lifestyles and health-related behaviours, for example smoking, diet and physical activity. Social networks and mutual support contribute to health as do the interaction of different social, economic, cultural, and environmental conditions which play a large part in

causing inequalities in women's health. Any one of these factors can adversely affect a woman's health. Some factors may also have greater impact on a woman's vulnerability to poor health than others, but the balance of influences can change with time.

**Figure 6.** The interplay of factors influencing women's health



Psychosocial factors such as hopelessness and a sense of lack of control increase women's risk of poor health and vulnerability, particularly as they are unable to adapt to challenges of their physical and social environments. They may not interact effectively with a social network, their peers and family, nor health, education, police and judiciary services for example that should provide support. They are more vulnerable to harm from their health-related behaviours such as poor diet and substance use, as well as from stress and mood disorders caused by a lack of income-generating opportunities, violence or heavy workload burden.

### 8.1.1 From reproduction and risk to a life span approach: rethinking women's health

Many studies in women's health do not pay sufficient attention to the elements of women's lives that lie outside the mother-child relationship and the dimensions of reproductive health. The intense focus on this relationship obscures the role of women as one that is primarily to give birth and rear children. Indeed, much of the public health discourse emphasizes that women must modify their own behaviour to become better wives, mothers or homemakers, to the exclusion of women's own

health concerns and many of the material and psychosocial determinants of health (Freedman, 1999; Wong, Li, Burris & Xiang, 1995). There is often little scope for understanding how behaviours are related to social conditions and constraints or how these constraints shape individual lives (Bannister & Schreiber, 2001; Shultz & Lempert, 2004). Where the social environment is examined for its relationship to specific indicators of women's health, critics (Moss, 2002; Wuest, Merritt-Gray, Berman & Ford-Gilboe, 2002) claim that social determinants of health are used as control variables that are decontextualized from the specific historical, political, legal and social contexts .

Socio-cultural studies show that cross-culturally, women see health as more than the absence of disease, having social, cultural, emotional and spiritual dimensions. However many studies on women's health centre on the problems of all women or that of selected age groups. This thesis looks at the universal issues that cut across age groups as well as the specific self-identified health needs of women as they move through the life span (Wyn & Solis, 2001). This is based on the understanding that women health reflects the totality of women's experiences throughout the life span.

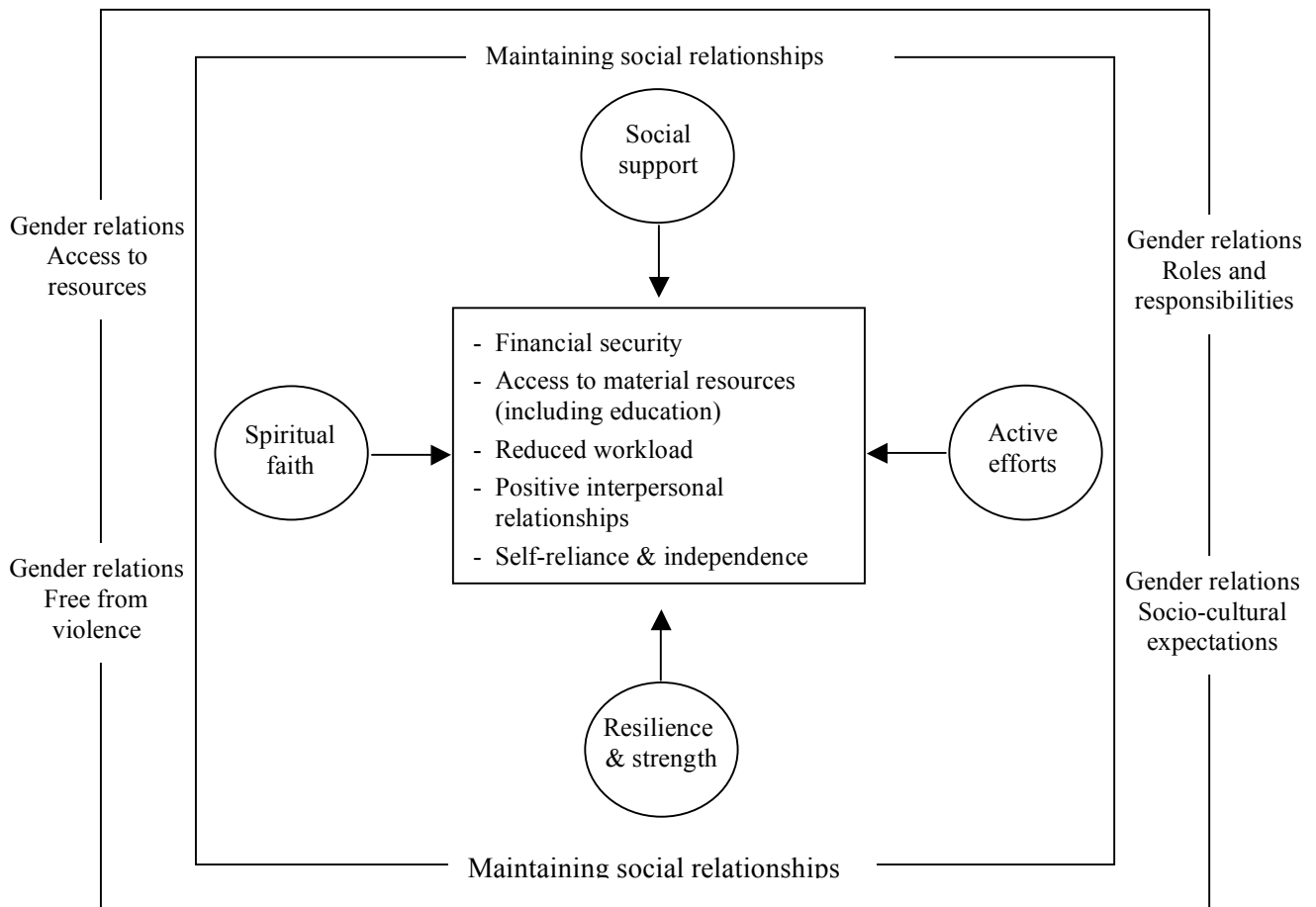
The study was conceptualised using an interpretative qualitative methodology within an ethnographic framework and was based on the accounts and real health-related experiences highlighted by women themselves. The research strategy used a within-method triangulation approach. A combination of qualitative and participatory methods was applied to explore the diverse health needs of women and the key determinants of women's health across the lifespan.

#### **8.1.1.1 Health as a social and cultural phenomenon**

Participant's accounts reiterate that women's health was related to the social and material circumstances of women's lives (see Figure 6). Health was a social and cultural experience, not an isolated and individual condition (see Chapter 3 & 4). Women's accounts of their health centered on five main factors (the inner box of Figure 6); the struggle for financial security; reducing an arduous workload; improved access to material resources; the impact of mutually beneficial relationships on health; and a self-reliant and independent self. Women described their efforts to maintain mental health (the four circular boxes) and to avert the

hopelessness and lack of confidence that some women described experiencing. Social support and spirituality were identified drivers of good health. Women also turned to and trusted in their own active efforts and developed resilience to maintain their health in response to challenging structural conditions.

**Figure 7.** The main factors contributing to women's health



Interestingly, reproductive health problems did not figure prominently among the health issues described by the women in this study. Instead, women's descriptions were based around their attempts to meet production demands and the material circumstances of their lives. Central to women's narratives was the negotiation of their social relationships and the influence of gender relations on health. Gender challenges and constraints (the outer box of Figure 6) were faced by women of all age groups. Women specifically reflected on the challenges associated with their efforts to manage their roles and responsibilities, contend with violence, improve their access to resources in a context that rendered them economically and socially indebted or dependent on husbands and male kin, and meet the expectations placed

on them to provide and care for themselves and their families. It was important to avoid arguments and serious conflict with kin as the alternative was poor social and physical health and reduced social cohesion. A complicated birth for example was perceived to be a consequence of the non-payment of brideprice or due to unresolved disputes within the family.

Sorcery was discussed by several women as the cause of unexplained illness or death. Different researchers have analyzed the spiritual determinants of health amongst the Abelam (Forge, 1970 Koczberksi & Curry, 1999). There are two kinds of responsibility for an unexplained illness or death, the sorcery technician and the person who hired and cooperated with the sorcerer, often someone close to the victim (Ayers Counts & Counts, 2004; Forge, 1970). Since the death or illness is caused by human action it is therefore important to ascertain the underlying cause of the fissure in social relationships. Although the women in this study did discuss sorcery, it was not an overriding issue in discussions.

The nature of women's relationships with others was perceived to be integral to health (the inner box of Figure 6). In the Wosera, obligations between relatives and the wider clan are morally binding, symbolizing the collective as opposed to the individual and social obligation rather than self-gratification (Keesing & Strathern, 1998). However, the respondents in this study were not completely "socio-centric" or enacting social patterns, without any agency (Josephides, 1991). Rather, in response to the progress of modernity, extremely difficult life circumstances and economic hardship, women displayed an inherent resilience and worked to negotiate and improve critical social relationships which they prioritized at different points in the life span.

The broader socioeconomic pressures evident in the Wosera are having an impact on the nature of social relationships and in response people are reassessing and redefining their relationships with spouses and other kin. In the Wosera, relations between opposite-sex siblings were an authoritative gendered relationship but the increasing importance of the marital relationship has been reinforced by brideprice and husbandly control over women's bodies and women's lives. Both women and men also agree that men perform less labour, relative to women, than they did in the

past due to increased need for cash, male out-migration, changing cultural patterns and shortage of fertile land. Similar to Dureau's descriptions of changing social patterns evidenced in the Solomon Islands in the 1990s, in the past, a woman who did not have a husband could rely on the help of her brothers for agricultural assistance but increasingly women are obliged to do the work themselves or to pay someone else to do it. The nuclear family is increasingly perceived as the structure within which labour is performed and money earned for the immediate needs of the family. This is having a detrimental impact on women's access to social support. Family members who normally provide assistance are facing their own economic pressures and responsibilities and may be reluctant to accept more. For example, for most women, their sisters' responsibilities and tasks are increasing at the same time as their own, thus rendering them less available for child care or gardening assistance.

Although early anthropological studies of the relationship between the sexes described one of "complementary opposition" (Scaglione, 1986; Kaberry, 1941), the adult women in this study described the need to seek supportive relationships in response to their multiple workload and the gendered inequalities they faced in daily life. Males were seen to be lacking in their complementary tasks and responsibilities, let alone in assisting women in the performance of their duties. Contrary to earlier research (Scaglione, 1986), the tone of spousal relations was not always friendly and relaxed.

Women's vulnerability, resilience and ability to adapt were entwined and affected their ability to withstand exposure to stresses and adversity (Earnest & Faulkner, 2009) and maintain good health. When women had a positive sense of wellbeing and emotional health, they felt 'healthy', less anxious, physically and mentally strong, and able to withstand adversity. There was an obvious connection in women's accounts between physical aptitude and mental strength and stability. For the women in this study, health was in fact a state of complete physical, mental and social wellbeing and not merely the absence of disease. As shown throughout Chapters 3 to 7, health was equated with wellbeing, an encompassing concept that took in consideration of the "whole person". Happiness and satisfaction with life equated with a good sense of wellbeing.

As discussed in Chapters 4 and 7, in a challenging environment, women valued self-assertion, self-worth and independence (Stewart & Strathern, 2000; Wardlow, 2006), often in opposition to cultural expectations and gender norms. Establishing self-reliance allowed women to gain some control over the constraints of daily life and reduced their dependence on external resources. Women strived to make the best of their own abilities and resources. The belief in their own potential strengthened women's confidence and capacity to deal with new and difficult challenges and made it possible for women to take care of themselves and their family.

In summary, this thesis suggests that the current approach to women's health in PNG, which focuses on maternal and reproductive health needs (which portrays only a partial image of women's health needs), must be broadened to reflect and respond to the multidimensional nature of women's health. The focus on reproductive health issues has sustained the prominence of the biomedical model of illness in women's health which is ambivalent to the social, cultural, contextual, political and environmental conditions that influence health across the life span. The understandings that follow are then reproduced as a true picture of reality.

### **8.1.2 Making the links – human rights, health and the conditions of women's lives**

Social inequities in health and the role of gender as a powerful determinant of health inequalities have received more attention in the literature in the last decade (Awumbila, 2006; Denton, Prus & Walters, 2004; Moss, 2002; Santow, 1995; Solar & Irwin, 2007). Gender biases in social organisation, resource allocation and discrimination in rights, norms and values, and the way in which health services and programs are designed and delivered, have a harmful effect on the health of millions of girls and women. Globally, women and children are overrepresented amongst people living in poverty. Broad evidence suggests that in many countries, women have a higher incidence of poverty than men and their poverty is more severe than that of men (Awumbila, 2006; Cohen, 1998; Craft, 1997). This is evidenced in the feminization of the AIDS epidemic (Farmer, 1999; Solar & Irwin, 2007) which is fuelled by male dominance and social structures that subordinate and control women and maintain disparities in social and economic power (Lepani, 2008). According to

UNAIDS/WHO (2008a) global estimates, women comprise 50% of people living with HIV, and over 60% in sub-Saharan Africa. Global literacy statistics show that 774 million people are illiterate and 64% of women make up the total (UNESCO, 2008). Statistics on female reproductive health reveal women's disadvantage in poor countries where high fertility and maternal mortality rates are prevalent.

Women's health and human rights movements and activism culminated in the 1994 International Conference on Population and Development (Cairo) and the 1995 Fourth World Conference on Women (Beijing). There was a growing global awareness that women's health needed to be understood and addressed within the economic, social and cultural context of individual women's lives. Health indicators showed that high maternal mortality rates were not being met by technological interventions and "magic bullet" solutions. The UN Commission of the Status of Women (CSW) conducted a 10 year review and appraisal of the Beijing Platform for Action to identify achievements, gaps and challenges for implementation. The CSW reiterated that inequitable outcomes for women were a result of women being excluded and discriminated against on the basis of being female and women globally continue to face serious violations of their human rights (United Nations, 2005).

#### **8.1.2.1 The condition of women's lives influences the way women experience health**

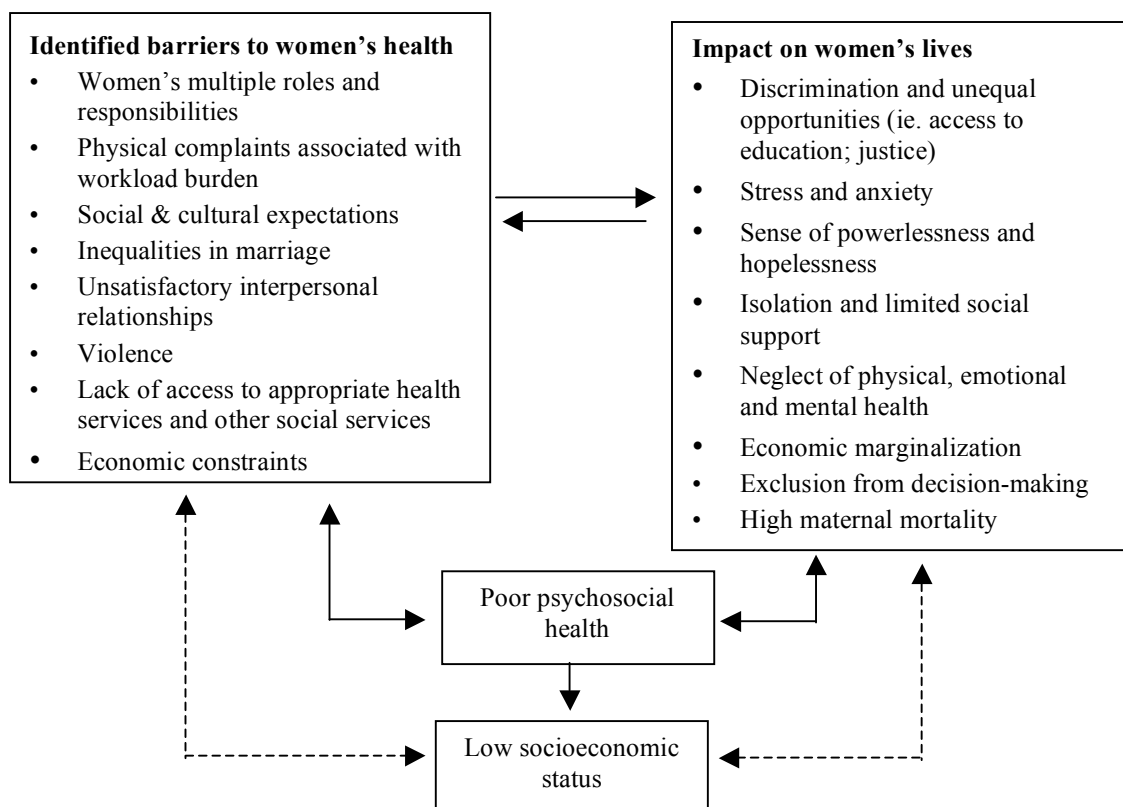
The findings from this study revealed that in the Wosera, women's work and the physical burden of women's roles, marriage and risk and experience of violence, and an unresponsive and inappropriate health service were major risk factors and barriers to women's health (see Chapter 5 and Figure 7). Women faced inequalities, discrimination and oppression in their everyday lives which affected their ability to achieve good health and perpetuated their low social status. Women's right to health was abused and neglected by women's parents, sons, brothers, husbands and other relatives at different stages of the life span.

The health system also proved unresponsive to the realities of women's lives and neglected to address the changing needs of women throughout their life cycle. Violence against women was the most pressing neglect of women's rights, given the



extent of the violations described in this study and elsewhere in PNG (Amnesty International, 2006; AusAID, 2008a; Toft, 1986).

**Figure 8.** Main barriers to health and the impact on health and women’s lives



### 8.1.2.2 Violence against women in PNG – a serious form of discrimination

The most comprehensive study of violence against women in Papua New Guinea is dated and was conducted under the auspices of the Law Reform Commission over 20 years ago (Toft, 1986). The study revealed that at least one in three women in Papua New Guinea experience violence in their lifetime. All available evidence and research (Amnesty International, 2005) and media reports (“Study shows high domestic violence in SHP,” 2008) indicate that violence against women in the home and the community is pervasive. Hermkens (2008) states that the various forms of violence against women, such as the physical, sexual, emotional, financial violence which contributes to women’s suffering, distress and worry reveal a “state of violence” that shapes women’s lives. Women and girls are “warned” by police and male relatives to follow the dictates of convention and alter their behaviour for their own safety. They are told to restrict their movements to specific times and places or to follow a certain style of dress. It then follows that sexual and physical violence

against women, whether in the private or public domain, is a consequence of female transgression and failure to heed warnings. Women therefore are to blame for their attack (Lepani, 2008).

Recent studies have focused on the links between gender, violence against women and HIV transmission and the social and economic impact on women (Hermkens, 2008; Lepani, 2008; Wardlow, 2006). Lewis, Maruia and Walker (2008) report high rates of physical and emotional abuse against women (58%) attending antenatal and voluntary counselling and testing services in four sites across the country. There was a strong link between violence in relationships and women's positive HIV status and women who reported sexual abuse in intimate partner relationships were twice as likely to be HIV positive compared with women who were not sexually abused.

In communities such as the Wosera, violence against women is facilitated by public social structures that refuse to take the issue seriously or treat the violence as a criminal act. Violence against women often happens in private spaces, the very area in which women are supposed to be safe, and a realm for which many state institutions, such as the judiciary and police, do not consider themselves to be responsible.

Violence is a serious form of discrimination against women in Papua New Guinea and women who experience violence are less able to realise a multitude of related rights, including the right to health, education, employment and decision-making. Economic deprivation due to lack of land and property rights, patterns of out-marriage, social isolation and financial abuse (Lewis, Maruia & Walker, 2008) make more women dependent on men for economic survival, reinforce expectations of male authority and increase women's exposure to male violence (AusAID, 2008a). The types of physical (poor nutrition, anaemia, bodily aches and pains) and psychosocial (stress, worry, sleeplessness, nausea) health problems related to violence and faced by women demonstrate the interplay of social and biomedical conditions that lead to poor morbidity and mortality rates seen in Papua New Guinea. Violence is a discernible and constant reminder of injustice against women in Papua New Guinea.

Gender equality and human rights are embedded in the constitution of Papua New Guinea and the PNG Medium Term Development Strategy (2005-2010) which provides the framework for government development spending and efforts to achieve the Millennium Development Goals. Women and men must be given the opportunity to develop as a whole person in relationship with others, and a complete relationship in marriage rests upon equality of rights and duties of the partners (Constitution of Papua New Guinea, 1975). Both of these points reflect the main health concerns women expressed and the type of relationship they desired with parents, spouses and health workers. However, there is a disconnect between political intentions and pro-equality rhetoric and policy outcomes. Despite the recognition of gender equality in the constitution, women's rights are perceived to be conflicting with "traditional" practice and "custom." Pressure for women's rights is dismissed by male leaders as culturally inappropriate and a product of Western feminism. Women are supposed to embody the continuity of custom, and as the mothers of future generations they remain symbolically outside of, and are disqualified from participating in, the political, bureaucratic and modern economic spheres (Macintyre, 2000).

### **8.1.2.3 Human rights is a development issue**

Continued ignorance and inattention to basic human rights in Papua New Guinea will continue to perpetuate poverty. There is limited practical application of human rights frameworks such as CEDAW (1981) and no established accountability mechanisms or systems for monitoring compliance. Much needs to be done to reverse decades of poor governance and improve safeguards for women and children. Some progress is being made by the Family and Sexual Violence Action Committee (FSVAC) which was established in 2000 to provide policy advice to government. FSVAC works with civil society throughout Papua New Guinea to increase awareness on legal rights, provide support to individuals affected by violence and facilitate the development of evidenced-based advocacy and policy frameworks. FSVAC has had success in advocating for legal reform, which culminated in amendments being made to the Criminal Code and Evidence Act in 2002, which included a clear definition for sexual offences against children and the criminalization of rape in marriage.

However, the State's commitment to international human rights frameworks has not been reflected or prioritized in national, provincial or district budgets. The limited

progress on women's rights in PNG is reflected in statistics. PNG has one of the lowest proportional representations of women in parliament in the world and the highest maternal mortality rate in the Pacific. Only 50% of women have access to education above primary level (WHO/WPRO, 2008) and in the Wosera the statistics are worse, with literacy rates among women at only 43%. Adult women in the Wosera are responsible for all subsistence production for domestic consumption, the management of the household and all childcare activities. Women face unreasonable societal and spousal expectations to meet these responsibilities with limited support, few sustainable livelihoods opportunities and low per capita incomes.

The Millennium Development Goals will not be realised without a commitment to gender equality by the State of Papua New Guinea. Apart from Goal 3 which directly, but narrowly, refers to gender equality and women's empowerment (in education alone), there are five other goals relating to poverty reduction, educational achievement, maternal mortality, infant mortality and combating HIV/AIDS, malaria and TB that will not be achieved without ensuring gender equality. However, we are currently at a point where neither Papua New Guinea has the capacity to set up its own human rights commission, and nor is there an established regional body in the Pacific region to monitor compliance to international human rights commitments or to investigate violations.

### **8.1.3 Can women deal with the stress of it all? The impact on women's psychosocial health and ability to cope**

#### **8.1.3.1 Worry and anxiety associated with women's attempts to address violent relationships and their most pressing health concerns**

The worry and anxiety associated with women's attempts to address violent relationships and their most pressing health concerns had a significant impact on women's health (see Chapter 6). The role of the psychosocial determinants of health, such as isolation, helplessness, lack of self-esteem, powerlessness and limited social support, is receiving more attention in the literature and in combination with a person's material circumstances and individual behaviour, can exert a powerful influence over health (Marmot, 2006). Research with marginalized groups in developed countries (Schulz & Lempert, 2004; Shaw et al., 2006) and from countries experiencing economic transition (Pietilä & Rytönen, 2008) has shown acute and

chronic stress to be related to a person's low perceived control over life, lack of optimism and trust in social institutions. Psychosocial health is influenced by an individual's socioeconomic conditions and access to the fundamental resources necessary to protect health, including adequate housing, good nutrition and opportunities to participate in society (Shaw et al., 2006).

The picture is similar in the Wosera to that reported in different settings. The material constraints women in this study faced were linked to significant emotional strain. Psychosocial factors, such as isolation, lack of support, depression and economic instability, were related to stress and anxiety and affected a woman's ability to cope with challenging material circumstances (see Figure 8). Lewis, Maruia & Walker's (2008) study of violence against women show social isolation and financial abuse, where a man limits a woman's independence in the relationship by not sharing financial and material resources, to be major causes of distress among women. Close to 40% of participants had experienced social isolation, where a man controls a woman's freedom of movement and restricts her from seeing family and friends. The constant abuse of women's rights maintained the low status of women and led to extreme inequities in reported physical health, specifically in terms of workload burden, violence, psychosocial strain, nutrition and access to health care. In this study, low social status was associated with the perception that a woman had very little personal influence on life circumstances and has been shown elsewhere to be a contributing factor in morbidity and mortality differences (Bosma, 2006; Shaw, et al., 2006).

Similar to the findings of Hou, Wang and Chung (2005), women had an elevated risk of depression and vulnerability to stress-related disorders. The more threatening and risky situation experienced, the greater of overall stress and loss of hope. The expressions of hopelessness and mood and anxiety conditions evidenced in the accounts of young unmarried women became more apparent and of critical concern in the descriptions of young married women and adult women. Lewis, Maruia & Walker (2008) found in their study of violence against women that women who reported partner abuse were older than those who did not. This suggests that women may be at greater risk of violence as their relationships develop over time.

Some young married women recalled experiencing social isolation, financial abuse and significant levels of physical violence and were somewhat perplexed by the nature of their abuse. Their relationships did not live up to the love-made marriages that they idealized. Young men's acts of violence against their wives were perceived by women and other community members (such as community police, village court, health workers and village leaders) to be a growing phenomenon related to male jealousy and aggression about female mobility and relationships, changing traditional work and socio-cultural roles and the growing dependence on the cash economy.

The "socialized fatalism" (Bosma, 2006) seen in early life can lead to a sense of powerless in later life, undermining adult women's resilience and effort to cope with difficult situations (Denton, et al., 1989). The extent to which a continuous struggle with stress had an impact on health was evident in the physical manifestations women described. These ranged from sleeplessness and loss of appetite to vomiting, fainting or unconsciousness. Mortality reporting is poor in PNG and suicide rates are difficult to distinguish from other causes of mortality. However, in the extreme, suicide was a woman's last attempt to gain control over and cope with unjust and difficult life circumstances. Suicide was not a solitary or individual act, but as is the underlying theme of this thesis, it was an expression of social relationships.

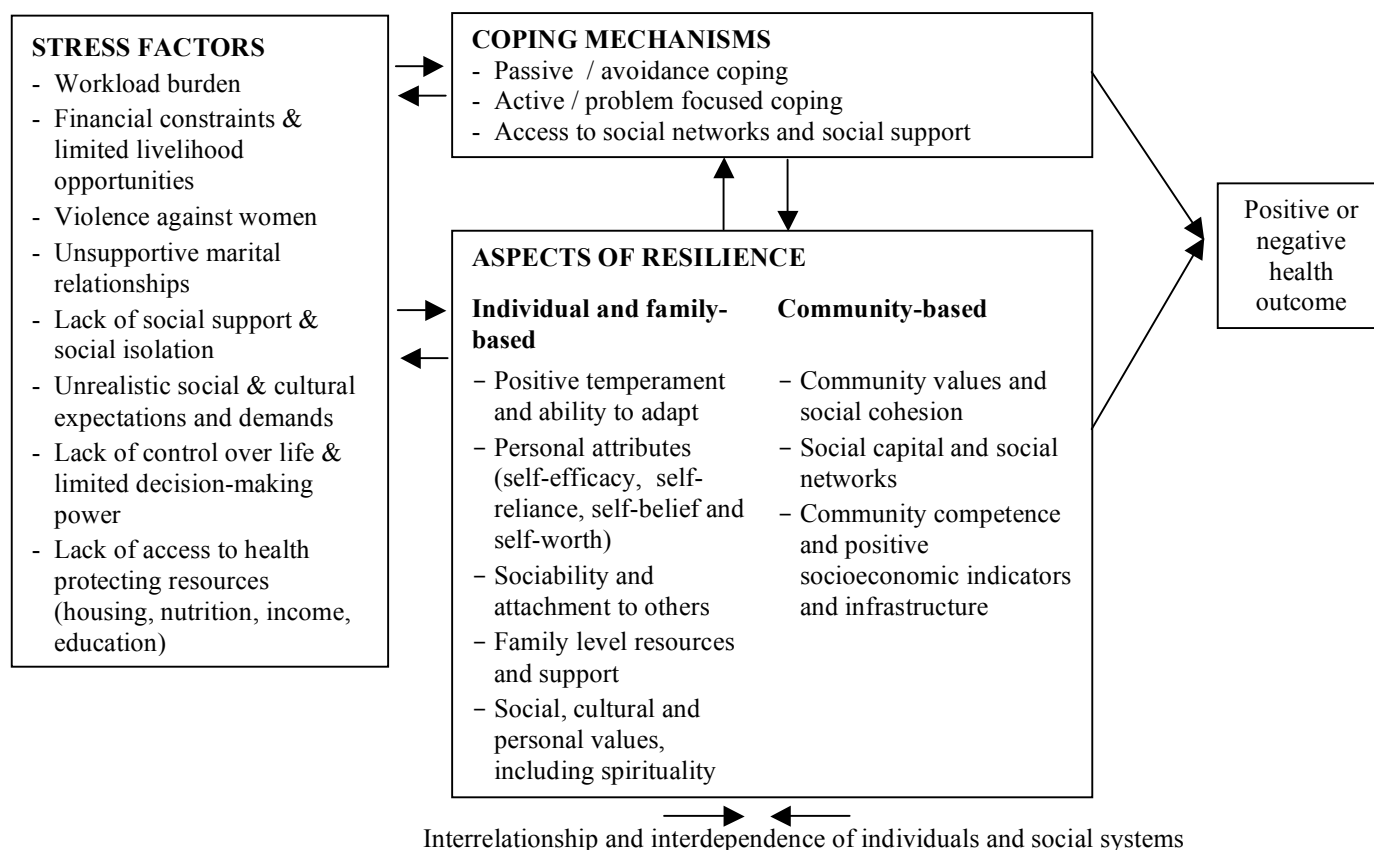
#### **8.1.3.2 The diversity of women's coping mechanisms and resilience**

Chapter 7 provides a much deeper examination of the diversity of women's coping mechanisms, which included, passive and active coping, access to networks and supportive social relationships and the resilience of women to confront the challenging circumstances of their lives. This paper showed the strength, assertiveness and resourcefulness of women in the face of extreme adversity. Many women developed and implemented strategies that required them to go well beyond conventional gender roles in order to ensure their own and their family's survival (Freedman, 1999).

The coping strategies women used to address their concerns and related stress, worry and anxiety were varied and dependent on a wide range of interconnected individual, family and community-based socio-cultural factors as outlined in Figure 8. The influence of these resilience factors meant that some women were better positioned

that others to cope with adversity. Women who had developed resilience, such as a positive outlook and perseverance, and were able to adapt and problem solve, were self-reliant and had supportive family and social networks, were less vulnerable to health risks.

**Figure 9.** Stress factors and socio-cultural dimensions related to women’s coping



*Passive coping* (avoidance / emotion-focused) was a strategy some women applied in response to their low socioeconomic position. Life was seen as a burden, not as a challenge that could be met with social, material or spiritual resources. They showed a lack of resilience and ability to cope with experiences of adversity, lacking in self-esteem and confidence. Women were threatened with violence, had restrictions placed on their movements, suffered physical disability due to their gender roles and responsibilities and were publicly humiliated if they attempted to step outside the confines of “customary” expectations. For example, maternal qualities such as having many children (as demanded and controlled by men), working hard to provide for them and ensuring surplus produce for communal exchange, were valued in the Wosera for the benefits that were given to the man’s lineage.

Women who performed these tasks selflessly were admired and respected, and those women who complained of a heavy workload burden and demanded a more mutually beneficial marital relationship were deemed as inadequate (Macintyre, n.d). A married woman's social status was derived from her association with her husband, with the rights to the products of her labour transferred from her father to her husband. As such a woman was limited in her ability to directly challenge male authority and her refusal to conform to male expectations and demands was not regarded as a form of resistance but as a failure of capacity (Macintyre, n.d). Women who valued greater autonomy were often at odds with their spouses and male kin and as such were accused of insubordination. Women were often disciplined with verbal abuse and physical violence or had their movements restricted for not effectively fulfilling their role as mothers, wives and daughters.

Another strategy women used to address the multiple constraints in daily life concerned *active coping* (task orientated) in terms of resourcefulness, assertiveness and resistance. Many women conveyed a sense of strength and capacity to exert control over one's life. Women saved, planned, strategized and looked for ways in which to survive social and economic hardship. Women spent more wisely than men and when given the opportunity were more likely to know how to manage household budgets. Compared with men who were seen to be irresponsible and wasteful with their money women spent their cash income on household necessities, food for the family and saved for school fees and customary distributions. In some settings in PNG, increased economic autonomy has enabled women to meet their domestic and cultural obligations with less stress and to redefine their identities and strengthen their relationships with family and community members (Koczberski, 2002).

Although all women faced constraints to their ability to cope, women with *access to social networks and supportive social relationships* were better able to deal with the barriers and constraints to their health. Young women for example who were well resourced within themselves, and had supportive family and social contexts, had greater capacity to respond to the demands and changes in their physical, psychological and social lives. Social networks and social support were prioritized as a health-enhancing resource by all women. A mother enjoyed the mutual benefits and support of living close to her daughter. Sisters looked to actively create opportunities



to engage with each other, or with other family members, friends and church members. Women's religious experiences and church networks helped women to deal with abusive partners and unsupportive relationships. Women looked for guidance, support and strength to deal with troubling issues and at the same time tried to accept their situation as being God's will. Hermken (2008) encountered similar expressions among Catholic women in Madang, who were struggling to balance their faith and the importance of marriage as a sacrament, with the realization of their own rights, health and wellbeing.

Social support was of utmost importance for women who were at risk of violence. A woman could look to address her problem through formal and legal avenues. However, in most cases no action would be taken by the relevant authorities to uphold legal orders or lawful processes. Often it proved too costly in terms of financial resources, time and emotional energy. It was more common for a woman to appeal to her kin and male relatives for social leverage and support. Women did acknowledge however, that traditional structures did not always provide adequate support, leaving women vulnerable to violence, less resilient and unable to access many of the social and economic resources necessary to protect health.

Broader political and social structural forces have an influence on health through their effects at the individual level. For example, there is a need for government support and for financial commitment to achieving health care goals which should work together with and support a woman's access to psychosocial resources. Access to economic resources can provide opportunities to purchase services, where government support is lacking, and meet associated costs of health care that would otherwise be unattainable.

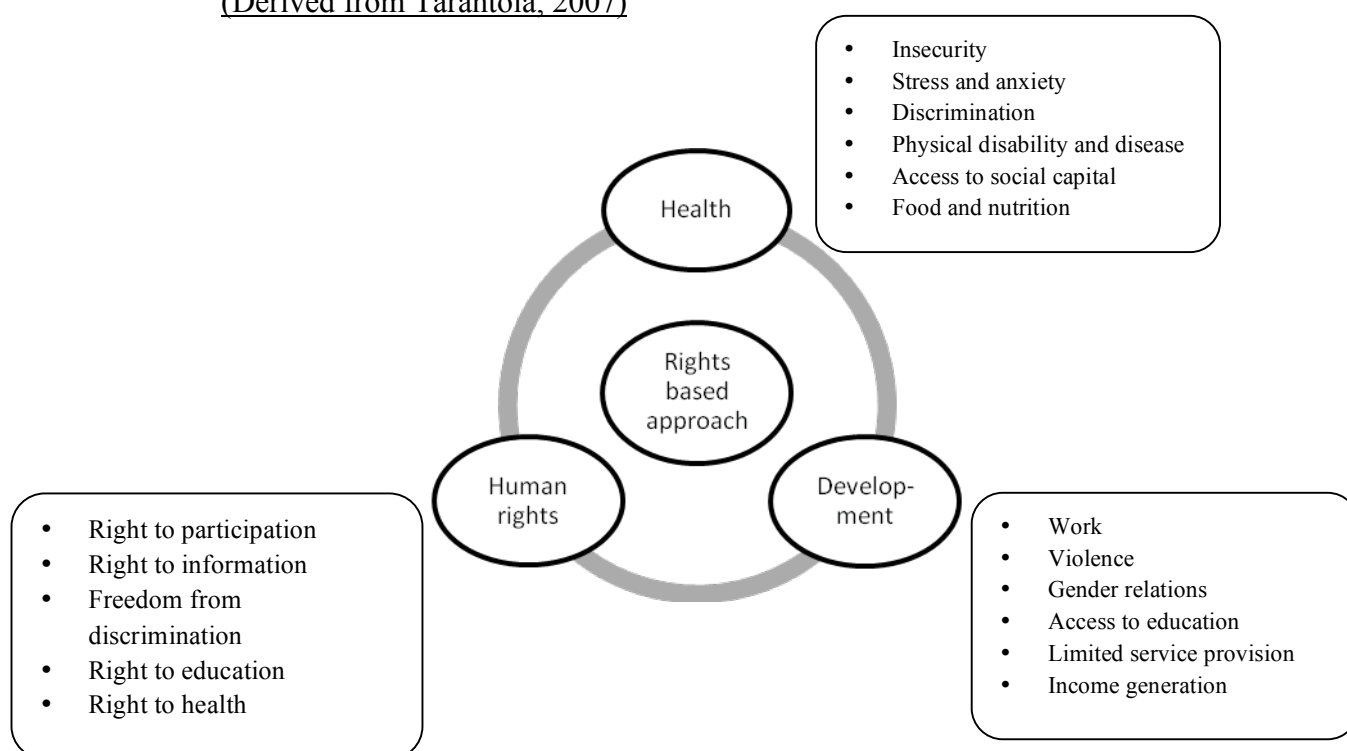
In summary, the psychosocial health needs of women were intrinsically linked to the material conditions of their lives. Women were restricted in their access to and control over the resources necessary to achieve the highest attainable standard of health. Women's choice of coping strategies reflected however, the importance of social support and active coping mechanisms for the maintenance of good health. The impact of passive coping on women's *inherent resilience* and women's health outcomes cannot be underestimated.

## 8.2 A rights-based approach to women's health: linking human rights and development in women's health

### 8.2.1 The interrelationship between health, human rights and development

This thesis advances our understanding of women's health in PNG by describing the impact of social conditions on women's physical and mental health, including gender discrimination, heavy workload and household responsibilities, unsupportive relationships, violence against women, and women's coping strategies in response. This study takes a step forward in integrating human rights with the examination of the relationship between women's health, socioeconomic status and women's opportunities to access health-protecting resources in PNG. Figure 9 shows the integral elements of a rights based approach to women's health and the reciprocal interaction between health, human rights and development (social, cultural, economic and political circumstances).

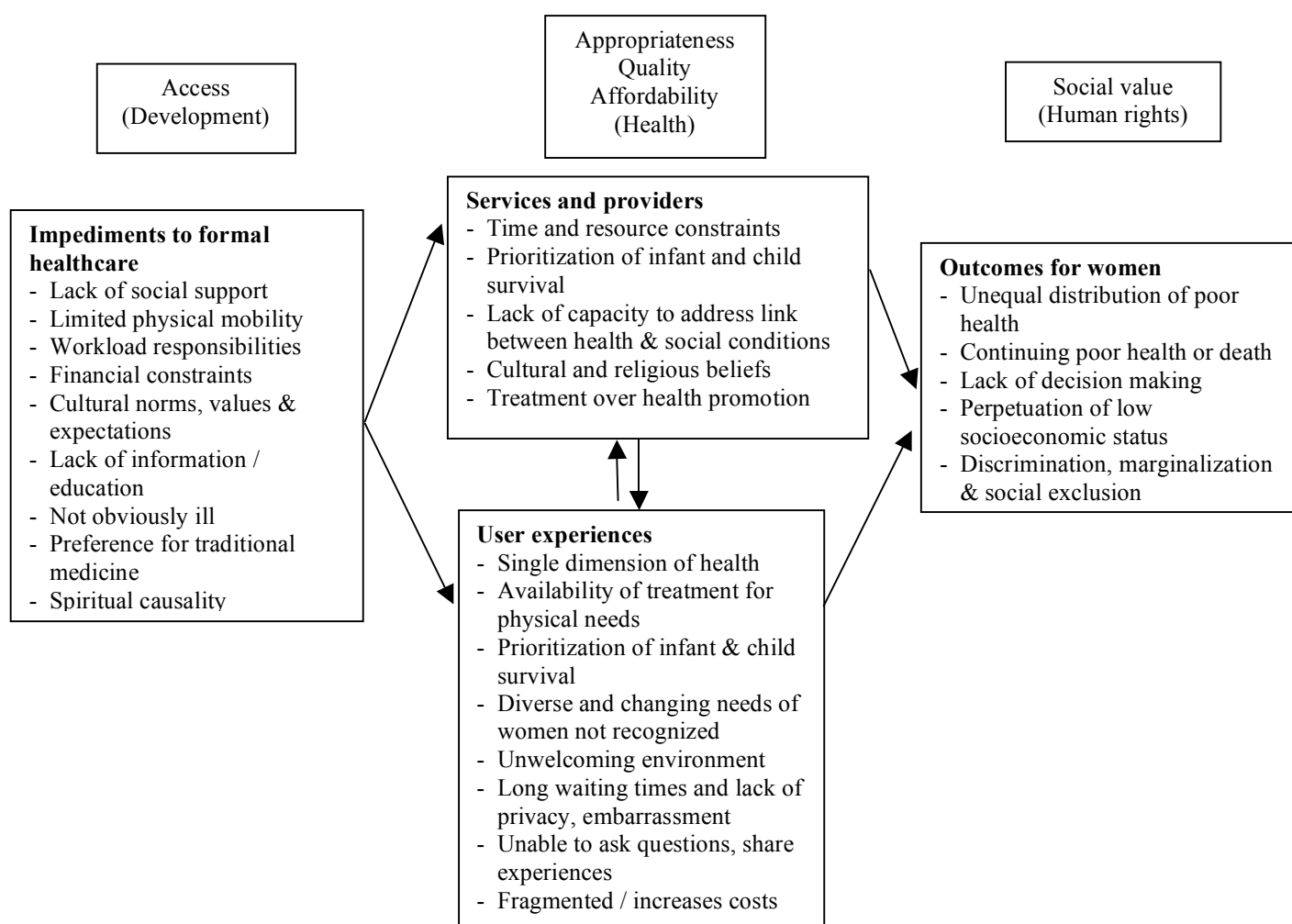
**Figure 10.** The interrelationship between health, development and human rights. (Derived from Tarantola, 2007)



When health is understood to include physical, mental and social wellbeing, a violation of a human right will impact negatively on health. Health policies,

programs and practices can promote or violate rights in the way they are designed and implemented and can present impediments to the access of health care (Gruskin & Tarantola, 2005). For example, it used to be law in Papua New Guinea that only married women could access family planning services from government facilities, with the consent of their husband (Wardlow, 2006). Although the law has changed, young single women in the Wosera are consistently prevented by health workers from accessing family planning information and contraception. This lack of attention and neglect of young women's rights influences young women's health outcomes and vulnerability to sexually transmitted infections, unwanted pregnancy and poor psychosocial health (see Figure 10).

**Figure 11.** Impediments to health care and the outcomes for women



Social, cultural, economic and political factors such as gender relations, lack of information, cultural norms or economic constraints, individually or in synergy, affect the way women are able to access appropriate, quality and affordable health

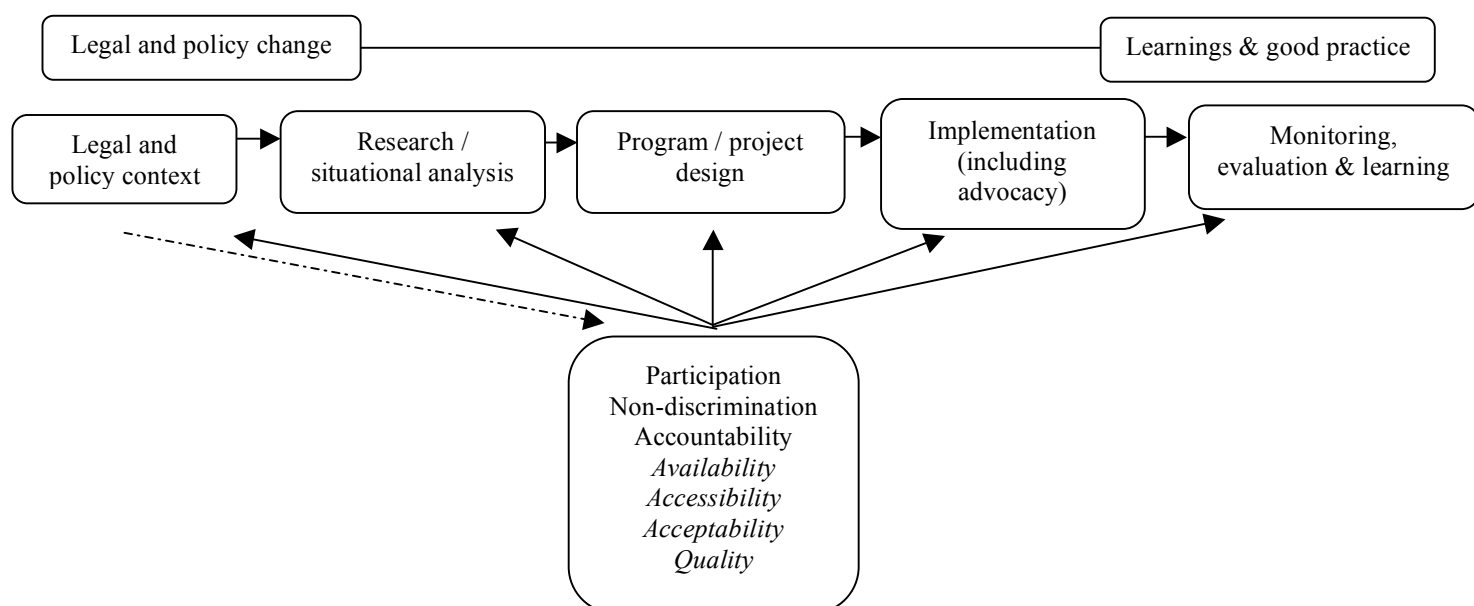
services or make free and informed decisions about their health and life (see Chapter 5 and figure 10). Women's experiences of service provision in turn influence the extent of their vulnerability to ill-health and the ability to realize their social, cultural and economic rights.

### **8.2.2 Applying a human rights approach to women's health**

The thesis proposes the development of a right-based framework to underpin future research and programs on women's health in Papua New Guinea and to strengthen the conceptual link between health, social conditions and the principles of human rights. A rights-based approach adds value to traditional health or development policy responses by promoting human rights, empowerment and social justice and by drawing attention to government accountability and responsibility as duty bearers for the health of a population. Human rights has been applied to health-related work in a variety of ways, but the areas of strategic focus generally fall within four domains; advocacy, application of legal standards, policy and programming (Gruskin & Tarantola, 2007; Gruskin, Mills & Tarantola, 2007).

A right-based approach to advocacy is used to draw attention to an issue (such as violence against women, sorcery killings, high rates of female illiteracy). The objective is to mobilize public opinion and use human rights standards as a platform for change in the actions of government, public and institutional policy and practice. A legal approach prioritizes the obligation of states to respect human rights law at international and national levels and promotes the implementation of norms, standards and accountability in health-related policy and programming efforts. A policy approach is designed to translate and integrate health and human rights norms and standards in global, national and organisational policies and policy-making efforts. A programmatic approach is concerned with the application and the implementation of rights in health programming, including the design, implementation, monitoring and evaluation of health policy, programs and interventions. This approach often integrates all four strategies and makes the connection between the policy/legal, program and community levels. The steps involved in the application of a rights-based approach to programming are shown in Figure 11

**Figure 12.** Applying a rights-based approach to health. (Adapted from Tarantola, 2007).



In order to address the reciprocal nature of health, development and human rights as outlined in figure 9, the immediate and root causes of a health issue (for example high maternal mortality) must be examined, the possible responses identified, especially where human rights are relevant, and a course of action determined (both long and short term), using the framework outlined in Figure 11. In practice the assessment, design, implementation, monitoring and evaluation of a health policy, strategy and program or intervention would incorporate the key components of participation, non-discrimination and accountability.

This would mean ensuring attention to the rights principles, such as the participation of affected communities and marginalized groups and non-discrimination in how policies and programs are carried out. The legislative and policy context would be examined for the impact on the development and implementation of programs and policies. In addition, governments and practitioners would be pressed to ensure transparency about how priorities are set and decisions made, and to be held accountable for their actions, systems and results. With the application of human rights standards, greater attention is paid to availability, accessibility, acceptability, quality and outcomes of policy, programs and interventions and would take into account the diversity and vulnerability of women throughout the lifespan (Gruskin & Tarantola, 2007).

Questions for a rights-based course of action to address the interrelationship between health, development and human rights are outlined in Table 6. The intent is not to offer a level of saturation but to provide an example of the types of questions that could be asked by policy-makers, practitioners, evaluators and community members at each stage of engagement. These questions would adapted with respect to the (interrelated) health concerns (such as violence against women, psychosocial health, economic constraints) at issue, and with respect to short and long term outcomes.

**Table 6.** Examples of questions to address the interrelationship between health, human rights and development. (Derived from Tarantola & Gruskin, 2007).

<b>Human rights elements</b>	<b>Participation</b>	<b>Attention to most vulnerable groups</b>	<b>Non-discrimination</b>	<b>Accountability</b>
<b>Health elements</b>				
Policy and legal contexts	Are the women most affected by the health concern involved in the drafting of policies that affect them?	Do policies refer to the diversity of women with regards to health and the social, economic and psychosocial determinants of health?	Are policies and laws discriminatory with regards to ill-health and its recognized social, economic and cultural determinants, practices and impacts?	Are policies and programs consistent with the law and human rights policies and standards?
Research / situational analysis of health of particular population or specific health problem	Have members of concerned governmental, private and civil society sectors participated in the design of the study?	Has the study recognized women most vulnerable to ill-health and focused on assessing their needs, situation and capacity?	Is the study in any way discriminatory in its design, conduct and analysis?	How and by whom will the results of the analysis be disseminated among political leaders, civil society, communities and the media.
Process of designing public health policy, program or intervention	Have divergent views been taken into consideration before a final decision was	Are sufficient attention and resources devoted to meet the diverse needs	Is the design or the policy or program in any way discriminatory?	Is the development of policy or program openly discussed with a

*Discussion, Recommendations, Conclusions*

	reached?	and vulnerability of women?		diverse group and vulnerable women or their representatives?
Implementation of policy, program or intervention	Are public information, education and participation effectively included the policy, program or intervention?	Are particularly vulnerable or affected groups of women engaged in implementing the policy, program or intervention?	Is implementation of the policy, program or intervention discriminatory in application and in what form is discrimination being perpetuated?	Does the implementation of the policy, program or intervention meet the criteria of availability, accessibility, acceptability and quality in the way it responds to the diverse needs women?
Framework for monitoring and evaluation against health, development and human rights benchmarks	Have targets been set and indicators defined with public participation?	Is implementation meeting the diverse needs of women, specifically vulnerable women?	Is the monitoring and evaluation system designed in a way to detect causes, practices and impacts of discriminatory actions?	Is there a mechanism to monitor, evaluate the implementation and impacts of the policy, program or intervention according to set criteria of availability, accessibility, acceptability and quality?

To optimize human rights in practice the above listed and other relevant questions by policymakers and development practitioners when reviewing policies and programs for their legitimacy, applicability and appropriateness from a human rights, health and development perspective (Tarantola & Gruskin, 2007).

**8.2.3 A rights-based approach to research in women’s health.**

The civil, political, economic, social and cultural factors that are related to a woman’s life, such as gender relations, violence or a lack of education, and the way a

combination of factors influences health, must form the basis to women's health research. Such an approach would take account of the diverse health problems that impact on women across different points in the life span and the barriers women face to achieving good health. Ignoring the complexity, diversity and contextual nature of women's lives contributes to increased vulnerability among women and raises a variety of human rights concerns, including the right to be free from discrimination and the right to participation. An explicit use of a human rights framework (with a focus on the principles of participation, discrimination and accountability) would add an extra component to Moss's (2002) model for the analysis of women's health inequities outlined in Chapter 1 and on which Table 5 is based.

A rights-based approach creates opportunities for research to be organized around a set of universal norms, standards and values for a systematic analysis of poverty, discrimination and inequity. It can draw attention to avenues for social and economic change and put forward explanations, a solid evidence base and examples of best practice to support government to apply human rights for the progressive achievement of better health outcomes.

### **8.3 Recommendations from the study**

The concepts of women's health discussed in this thesis challenge providers, practitioners, donors and policy-makers to rethink traditional assumptions about women's health care and health programs. Several suggestions are offered to advance the agenda of women's health in Papua New Guinea, based on the voices of women and main themes outlined in this thesis. Some of these recommendations may seem ambitious in the context of funding limitations and entrenched inequalities, however, it is in this context that women continue to experience poor health and in this author's opinion, only serves to reinforce the value of these recommendations.

#### **8.3.1 Recommendation 1: for Policymakers and practitioners**

Policymakers and practitioners must work towards the development of comprehensive, appropriate and quality health care that meets the needs of the "whole" woman. The policy objective of the expanded view of health ensures all women access comprehensive medical and psychosocial services that incorporate



both reproductive and non-reproductive health services in a continuum of care across the life span. The organisational and conceptual structure of the health service is still restricted to clinical values and women's health problems are seen to lie within the province of the health care sector. Separating services for women according to body parts or temporary conditions such as pregnancy does not ensure the health of women.

Women's health should be an end in itself, not just a means to achieve other ends. This means serving women throughout their lives, extending the population served beyond traditionally defined "reproductive years" (15 to 44 years) to include preadolescent through the transition to menopause and beyond. Programs that simply focus on maternal and child health and family planning do not meet the needs of older women or younger children. This study shows that the needs of older women and young women are not well met by existing programs. Women's health must be situated in the life course of women. Women identified that their health is responsive to their roles and responsibilities in marriage and within families and their position within the harsh socioeconomic environment.

Policy makers need to develop a gender sensitive approach to health care that is, integrated, collaborative, personal and communication based. The women in this study were concerned that health workers did not understand the importance of people and relationships to them or listen and let them know that their worries were being heard. A gender sensitive approach calls for improving communication by emphasizing provider knowledge of women's health problems and concerns, the provision of complete information to women and joint decision-making.

Women must be treated with respect and be partners in health care programs that impact on their health and wellbeing. This study has shown that women have a keen sense of their health priorities and must be encouraged to participate in the formulation of policies and programs that will affect them. Health practitioners must encourage women's choice in reproductive and other health matters, regardless of age and marital status. All women must be encouraged to seek information and education so they can make informed decisions.

Innovative models of women's health care in different development contexts provide possible organisational models for change. Appropriately designed for the local social and cultural context, they offer women centered care to fill gaps in official and often fragmented service provision and provide a variety of services created in an attempt to help women meet their own health needs. Nationally designated Centres of Excellence (CoEs) in Women's Health in the United States provide primary care (reproductive health and preventive) services for women throughout the lifespan, in a supportive and welcoming environment. The CoEs have a high visibility of female providers, provide availability of information of particular interest to women and an absence of materials and attitudes that would be perceived to be threatening or inappropriate (Milliken, Freund, Pregler, Reed, Carlson, Derman, et al., 2001).

Women's health centers in Australia offer important examples of women's centered care. A wide range of services have emerged nation-wide for marginalized and vulnerable groups of women (indigenous, immigrant, abused, youth). Although the specifics might vary, the centers are designed to improve the wellbeing of women by taking comprehensive, integrated, relevant and women-focused approach to care. Services help women to allay vulnerabilities to ill-health through capacity building, the provision of clinical care, psychosocial support and strengthened social networks, and the opportunity for women to make informed decisions about their health.

Indigenous community controlled health centers in parts of Australia provide a holistic and culturally appropriate health care service to Aboriginal people. Such centers offer extremely worthwhile insights into the development and management of health care services that focus on empowering rural and indigenous communities to take control of their own health and lives. The services provided are multidimensional and can include, but are not limited to maternal and child health, counseling and the provision of shelters for the homeless, anger management and parenting skills, drug and alcohol clinics, suicide intervention and prevention, sexual health services and violence prevention and legal services. Programs and services are provided to Aboriginal individuals, families and communities in a safe and culturally appropriate space.

The Bangladesh Women's Health Coalition (BWHC) has established a health service delivery model where underprivileged and marginalized women can access a wide range of health services which complement development initiatives. The organisation runs 40 reproductive health centers with services ranging from family planning and safe motherhood to adolescent family life education and counseling. Emphasis is placed on both clinic and community based activities, and the integration of action-orientated community education.

Policy makers and programmers in Papua New Guinea must learn from these services and initiatives as practical and potentially replicable examples of good practice. As recommended in Chapter 3, the WHO strategic framework provides an appropriate model for assessing and managing women's health. Unlike the majority of reproductive health services in PNG, it provides the scope to assess and manage women's health within a broader context of health, explore viable program alternatives and encourage multidisciplinary stakeholder involvement, beyond the health sector. Its bottom up, participatory approach has proven useful for other resource challenged developing countries to identify and meet women's health priorities at the programming and policy level.

Individual projects cannot meet the universal need for appropriate, accessible and high quality health care in Papua New Guinea. Women's health advocates must therefore campaign for change in the organisation, funding and content of mainstream health services (MCH, antenatal clinic) and organisations which deal with women (church and faith based, NGOs) in order to reach the majority of women who live in rural areas.

### **8.3.2 Recommendation 2: for Health services - incorporating a relational perspective to women's health care**

Women's relationships with others must be understood and prioritized as integral to the development of women's health programs. Women's perceptions of their health are interwoven with stories and narratives of social relationships. Women are part of a nexus of social relationships (Strathern, 1988), between spouses, siblings, parents, children, in-laws, friends and boyfriends. The implication is that there is interplay

between individual health and the relational and interpersonal context of a woman's life.

Health services must look further than women. This study recommends the incorporation of a relational perspective to women's health care. This is critical since most of the health problems experienced by women can be attributed to the poor quality of social relationships. Although addressing the conduct of relationships might seem outside the purview of the health system, it is the system that has to deal with the consequences of relationship difficulties. From talking with women it became clear for example that the focus of health education must extend to families and relationships, and not directed at women in isolation. An adult and young woman's husband, friends and family are obvious targets of health promotion and health education programs. Health programs and services must also provide support to women to improve their connection with friends and families. This is important since most women relied on informal social networks for social, cultural and economic support.

A spectrum of programs must be developed to promote family relationships, parenting skills, life skills and physical and psychological self-care for children and adolescents, based on building self-esteem and empowerment. Young women expressed a desire to cultivate health enhancing friendships and it will therefore be important to further develop the psychosocial health of young women through education, communication, positive relationships and leadership skills. Teachers and other institutional socializers (church and sports leaders) must be sensitized to gender and human rights, and given the skills to provide relationship and life skills for male and female students. Peers and family members could also be trained as mentors to act as role models to motivate and spend time with young women. This could build on similar types of relationships that some young women had developed with key family members. Mentoring programs can provide a medium for family members to engage with youth, build their self-esteem and empower young people in a culturally acceptable way (Mohajer, Bessarab & Earnest, 2009).

Peer education programs, particularly in the area of HIV prevention, which promote young people's autonomy and look to address the relationship between gender

inequalities and health (Campbell and MacPhail, 2002) must also be assessed for the effectiveness of the approaches used, the potential to replicate and the relevance for improving the health of young women. Operational research into the health-related messages that adolescents would listen to and accept and the entry points for engagement (such as church, sporting activities, school) is urgently required. Adolescents must be encouraged to participate in programs to improve their health and wellbeing

### **8.3.3 Recommendation 3: for the Government and Ministry of Health in PNG**

Commitment must be shown by the Government of Papua New Guinea to social change and empowerment for women if equality for women is to be achieved in Papua New Guinea. The State of Papua New Guinea must improve other aspects of women's status in order to improve women's health. Changes are required to broaden the social structures which restrict women's ability to maintain their own health, improve their status and realize their rights. In the short term, advocacy and political action is essential for increasing attention to women's health. In the longer term, changes are required to deeply held values and male centered social attitudes, supported by budget allocations and program strategies.

Many women's health problems are a result of gender discrimination and ultimately derive from male centered social attitudes, whether of a spouse or a policy maker. A better understanding of male masculinity, male attitudes and behaviours is urgently needed. The first step is to recognize in social policy and the wider community that these attitudes are central to girls and women's health. Women's vulnerability to risk can not be separated from the attitude and behaviour of men or examined in isolation from the existing gender power inequalities. Men must be sensitized to gender issues, directly involved in efforts to shift entrenched gender inequalities and urged to realize their obligations and responsibilities towards improving women's health.

To enhance long term sustainability of current interventions, it will be important to reduce gender differentials and to meet women's perceived needs through social and political action. Programming efforts for women's health must therefore focus on women's perceived needs and strengths. Successful and sustainable projects to improve the health of women in PNG depend on developing an understanding of

women's perspectives of their health within their socioeconomic context. When the perceived needs of women are neglected in favour of measurable indicators and risk factors, projects run the danger of homogenizing women and are inadequate for making progress towards real improvements in the socioeconomic status of women. The process must be participatory and inclusive. Women must be involved in policy development and the planning and implementation of new projects that facilitate their empowerment, increase their capacity for decision-making and improve their domestic situation. Educational and program activities must also promote young women's awareness about gender inequities, rights and health.

#### **8.3.4 Recommendation 4: for the support of local groups and community organisations**

Programmers must support local groups and learn from local approaches to improving women's health status. This will help to identify appropriate entry points to engage with communities. Entry points can be wide ranging - to strengthen the rule of law, improve housing, support income-generating opportunities, literacy or improve governance - and as a starting point, approaches to health must be broadened to encompass this. Empowerment strategies do not have to focus explicitly on health in order to affect the health.

Although the women in this study felt confident to articulate their concerns and health problems, they were much more hesitant when it came to identifying solutions and ways to overcome the problems they faced. Women may have felt genuinely trapped, unsure of what was being asked of them or perhaps skeptical about the likelihood of change. However, women were well aware of the aspects of their lives that needed to change and when given the space to talk they drew attention to improved livelihoods and relationships, which would not only improve their own health, but would translate to improved health and wellbeing of their families.

Providing a voice to vulnerable women will draw attention to appropriate intervention strategies and alternative models for improving health. Interventions must take the time to identify and build on the existing skills and knowledge of women and engage both men and women, young and old. The challenge is to transform existing gender divisions to effect real change in women's perception of

themselves (and men's perceptions of themselves and of women) and in their social and economic circumstances in a sustainable way. Further exploration is required of the ways in which community based empowerment strategies and income-generation might be used to enhance group cohesion, foster economic independence and positive behaviour change.

There are many examples in the international literature of community-based empowerment strategies and communities dealing with their own health problems (such as indigenous Australian community health centers, and Indian "health animators" who are trained volunteers working on health promotion and socio-cultural action at the grassroots level). At the country-level however, the approach and activities of Kup Women for Peace (KWP) provide a powerful example of locally driven empowerment to improve human rights, health and wellbeing. KWP is a local non-government peacebuilding organisation in the Highlands of PNG that has worked for the last decade to prevent conflict and violence in its communities by investing in development. Their activities are wide-ranging and include improving local community justice and mediation structures (and integrating formal government structures in the process), creating non-violent alternatives to gun-based livelihoods, care and counseling for marginalized groups (abused women, people living with HIV/AIDS), and human rights and gender training.

Integral to KWP's approach is a focus on gender justice, to increase women's role in peacebuilding and to reduce violence against women. A real shift in mindsets about violence and peacebuilding has been closely connected to a second shift in perceptions about women and their roles in the community (see Hinton, Kopi, Apa, Sil, Kini, Kai, et al., 2008) and related to a more general sensitization in the community about human rights, gender justice and violence. There is much potential for the psychological and economic empowerment that is advocated in the global campaign for women's rights.

It is important to be realistic however about what can be achieved in terms of the operationalization of women's empowerment, particularly in societies such as Papua New Guinea where the status of women is low and women face structural discrimination (in social, economic and political structures) and inequalities in the

control and distribution of resources in their everyday lives. Empowering women in one area of their lives, such as through improved economic opportunities (such as Lus Fruit mamas), does not necessarily mean other aspects of women's lives will improve due to the complex socio-political conditions and psychosocial factors that influence health. Women may be better positioned to negotiate, make decisions, know where to go for help, but they are still part of a wider system that discriminates against them. They are situated within a weak system of governance and women's access to social and economic resources is severely restricted.

Many women in PNG work tirelessly to change the structures in society to improve the rights of women. They are a small, yet significant group. They have developed knowledge, skills and confidence to engage in collective action to challenge the gender hierarchy. However, many women remain powerless to prevent their husband taking a second wife, they are still beaten and abused and their concerns are dismissed by the police and judiciary. There are many issues for consideration. For example, a woman can leave her husband, but in a society where land and property rights are, in the majority patrilineal, women are economically and socially disadvantaged, particularly if their family does not support the separation. Empowerment projects will not produce sustainable health outcomes in PNG in the absence of socio-cultural understandings of women's lives and social policies that are translated and implemented in practice to protect women from discrimination, violence and ensure access to health-protecting resources (Weisman, 2000).

Because women's status is so low in PNG, increasing their participation in political leadership positions and improving their economic and social status at all levels must be a priority. This means strengthening women's participation and decision-making in community development programs, as well as increasing their representation in national-level leadership, including national government (AusAID, 2008a). Despite serious opposition (both inside and outside of government) there is currently a push in PNG to guarantee 3 seats in Parliament for women. The process of social change is slow, however, specific steps in a process of empowering vulnerable groups at a grassroots level must be considered by policymakers, programmers and practitioners.



- Community mobilization and long-term community engagement, specifically focused on strengthening community cohesion through improved human rights, must be prioritized.
- Human rights and gender justice must be integrated in programs in order to challenge the power imbalances between men and women and to promote the development of the whole community. This would include working with institutions (such as police, judiciary, correctional services) to help them understand and integrate a commitment to human rights and gender equality into all structures, policies, and procedures that govern conflict.
- Any approach must be directed at the use of local resources, expertise and skills and built around local ownership.
- Long term engagement must be prioritized over short term solutions. Top-down approaches are by themselves inadequate without parallel and consistent work at ground level.

Further examination is required of the approaches and conditions under which empowerment initiatives and broader social movement advocacy and activity do in fact effect change in social institutions and improve the health and wellbeing of women.

### **8.3.5 Recommendation 5: Reducing violence against women must be a political goal that can be translated into meaningful action**

Major development partners to the PNG government and national and international NGOs must strengthen the campaign against violence against women and children and demand it be given higher priority on the political agenda. There is little doubt that violence against women is a cost to development in PNG, yet legislation alone cannot work. The state of PNG must turn from a dependency on legislation to other means in a genuine attempt to reduce violence against women and that reach rural communities. Any solution to the lessening of violence must break the perception that it is acceptable to be violent. Violence exists between tribes, sub-clans, between and within families. As Mary Kini from Kup Women for Peace stated recently at the Fifth Pacific Regional Meeting on Violence Against Women, “due to the widespread nature of violence in Papua New Guinea, when it comes to eliminating gender-based violence, the approach must be holistic to address the root causes of our violent

culture”. Patriarchal attitudes of male control and authority that reinforce the inferior status of women must therefore be challenged. Men must be educated about rights and violence and held accountable for their violent actions.

To reiterate, the State must pursue a course of changing attitudes rather than relying on punitive measures to address violence. Policy must also be informed by the solutions and successes of local women-led organisations in PNG (such as Kup Women for Peace; Leitana Nehan Women’s Development Agency). These organisations use innovative models to promote women’s rights, address violence against women by changing male attitudes towards women, and tackle the growing problem of insecurity and armed violence in their communities. This includes improving local mediation structures to promote dialogue and capacity for conflict resolution within families and the community more generally.

Competency-based training is urgently required to develop specific skills to address cases of violence against women and children (AusAID, 2008a). Health workers treating women for mental health problems must also be trained to recognize that violence is associated with common disorders such as stress and inability to sleep. Awareness of violence against women as a significant risk to health needs to be clarified within the health sector and all organisations and services that deal with women must address the issue of violence against women when assessing their needs. Gender based violence has also been shown to be a risk factor in HIV transmission thus community education together with Voluntary Counseling and Testing (VCT) services must integrate strategies to reduce violence against women.

This awareness must be further extended to the media and general public in support of population-wide and community based interventions to decrease violence. This can build on the learnings of “*Yumi Lukautim Mosbi Projek*,” a Port Moresby based awareness program that uses the media to advocate for a clean and secure city and is taking a strong stance in the campaign to address violence against women. This also includes a new initiative “*Meri Seif Ples*,” established in partnership between government (National Capital District Commission), the private sector (Digicel, Port Moresby Chamber of Commerce and Industry and Protect Security) and civil society (*Yumi Lukautim Mosbi Projek*). The initiative is building on the work of three

established safe houses in Port Moresby (provided by Haus Ruth, YWCA and ICRAF) and provides transport and access to emergency and temporary shelter for women and their children and related counseling services help to deal with the psychosocial impact of violence and abuse. National male champions on violence against women have been part of the campaign. Male advocates must be cultivated at both the national and community-level in order to educate men and challenge existing socio-cultural structures that facilitate violence.

Sexual offences squads that were established in each Province in the late 80s to facilitate the reporting and prosecution of perpetrators of sexual offences are not functioning. The Family and Sexual violence desk at Boroko Police Station in Port Moresby was established with strategic funding from AusAID and is providing improved support to women affected by sexual violence. It is reported that officers are dealing with over 15 new cases each day.

**8.3.6 Recommendation 6: Recognizing the need for a comprehensive, intersectoral and participatory approach to understanding and improving women's health**

The health sector itself has little or no direct control over most of the underlying conditions necessary for health. The State of Papua New Guinea must support and coordinate the collaboration of the health sector with other sectors that do not usually partner with the health sector. This would include the Ministries of Education, Community Development, Environment and Internal Security. Therefore it must become mandatory for sectoral committees within government to convene. They must be required to develop strategic plans in light of human rights concerns and the distribution of and access to social and economic resources. Civil society must also continue to engage with the government of Papua New Guinea on the underlying determinants of health and the structures that continue to impede women's right to health. Targeting the broader determinants of health will contribute to increased intersectoral consultation and collaboration.

Many programs may not have the capacity to provide comprehensive women's health services by themselves. There are several interrelated courses of action. First, an expanded view of women's health must be seen as opportunity to broaden the

scope and improve the quality of existing programs already providing services to women. Second, to support this process, health providers must be encouraged to forge linkages with other programs and organisations and use local and international non-government organisations, such as Save the Children PNG and World Vision PNG, and government structures, such as the National Council of Women, as intermediaries to reach women. It will be particularly important in the current context of limited resources to develop a network of providers of psychosocial and mental health services and to develop a locally and culturally appropriate system of referral and counseling.

**8.3.7 Recommendation 7: A human rights framework must provide the foundation for addressing inequities in women's health**

The government of Papua New Guinea, especially the relevant ministries (health, law and justice, community development) must be supported, assisted and educated by donors (assuming donors show political will) and human rights specialists to systematically prioritize and integrate human rights perspectives (Figure 11) into all health sector actions. This will ensure systematic attention to social disadvantage, vulnerability and discrimination in health policy and programs. Significant financial investment must reflect this paradigm shift. Simple and practical tools must be developed for personnel to use in practice and dedicated training and ongoing support provided to all professional levels. Capacity building programs must be designed for both male and female health workers, with a focus not just on “women's issues” but on the wider question of gender and human rights.

The government of Papua New Guinea must be strongly encouraged by its major donors to build an environment that supports the adoption of rights based approaches by the health community. All bodies responsible for the training of health professionals should integrate human rights education and training at all professional levels. The operationalization of human rights in health requires commitment at all levels to support the endeavor. This will help to overcome impediments to the design and implementation of rights-based programs, particularly when many health professionals might not have heard of the right to health or what it means in a conceptual or operational sense. In-depth training and ongoing support must be given to support health professionals to appreciate the human rights dimensions of their

work, to understand the principles of non-discrimination, accountability and participation. Health professional must be trained to use health-related rights (such as right to participation, right to information, right to privacy, freedom from discrimination) to devise more equitable programs, place important issues higher up the national and international agenda, raise funds and ensure better coordination across sectors. It must also be recognized that many female health workers in Papua New Guinea are affected by and living with violence and human rights abuses in their own lives.

Awareness by civil society and human rights advocates in PNG must emphasize that human rights is subject to progressive realization, meaning States are expected to do better next year than they are doing today. To achieve progressive realization of human rights, donors and civil society actors in Papua New Guinea must also develop accessible, transparent and independent effective mechanisms of monitoring and evaluating progress in relation to health and human rights. This will compel the State of Papua New Guinea to explain what it is doing, why and how it is moving towards the realization of the right to health and its other commitments to international frameworks, including the Millennium Development Goals and CEDAW.

#### **8.4 Recommendations for research**

This study has provided an alternative understanding of women's health in PNG. We need to know much more about women's own perceptions of health and perceived barriers to health in both rural and urban contexts. Many studies in women's health refer to variables such as age, marriage and education which are easily quantifiable whereas other crucial variables such as status, gender based power relations and custom and culture remain poorly understood. This is despite these variables being invoked as major determinants of women's health.

Qualitative techniques and methodologies provide new and meaningful insights for women's health. Participatory, action-based, qualitative research must start to underpin the planning and development of programs for women. Most often women are passive subjects of epidemiological surveys or "needs analyses," having research

done on them. Although survey research is necessary and is used by large organisations like the World Bank and UNDP for programming purposes, surveys fail to capture disparities and hidden socio-cultural vulnerabilities and are not sufficient for understanding the social, economic and cultural context of women's lives.

Participatory action-research gives control to the marginalized and empowers people to effectively take control of their own situation. In the case of women's health programming, women must be encouraged to take an active role in the design, implementation and evaluation of projects, and through this participation, gain new knowledge, skills, self-esteem and confidence. The information that emerges through the active and full participation of women must be directly used to improve women's lives and strategic needs, (decision-making, reduced violence, improved support networks) together with advocacy, education, capacity building and socio-political action. The translation of findings into advocacy, policy and practice is an approach that empowers women to develop their own criteria of health, attempt to understand, strengthen and build on local solutions and strategies and develop their own ideas about what appropriate interventions may look like. It is also important to understand the conditions under which empowerment projects are able to challenge and change the social, economic and political structures that sustain the inequities affecting women's health and improve the health and wellbeing of women and their families (Meleis, 2005).

The process and quality of care that women receive once they are in the health system and any barriers to treatment, communication and decision-making are important areas of continued research. We need to explore how health systems and services in Papua New Guinea can be offered in a fair and considerate manner and can be used by all, particular those who are most vulnerable to ill-health. Further research is also required to identify ways to improve interpersonal relations between women and health providers. This would enable health providers to focus on gender-based and context-related problems of the patient rather than the symptoms of the problems alone.

An important aspect of improved communication between health providers and women is the identification of the psychosocial health needs of women and an analysis of the coping strategies of women. Further research and an in-depth examination of women who report low levels of psychosocial strain and active coping mechanisms is required. The aim would be to learn about the contributing and inherent resilience factors (structural, material, behavioural and psychosocial) to higher levels of self-esteem, motivation and sense of autonomy among some women, and not others, and the links to health outcomes. In order to improve health-related programs for women, gender-related research must focus more on identifying and engaging with the most vulnerable groups *among* women.

Research is also required on improving governance and specific measures that the State of Papua New Guinea can adopt to take concrete steps towards the realization of the right to health for all women. This would include analyzing the political, cultural and the social context as well as other reasons for the government's lack of commitment to the integration of human rights in policy and failure to support human rights efforts with equitable resource allocation. Health related rights give rise to immediate obligations that are not subject to the availability of resources. Further research in PNG is required to clarify what these immediate obligations are in the health context (United Nations, 2007).

### **8.5 Significance of the research**

Persistent disparities in health are among the most pressing public health concerns of our time. PNG women have the worst health indicators within the Pacific region. If a woman is fortunate enough to survive infancy, she faces the very real threat of dying in childbirth. Life expectancy drops by at least 20 years for women if they are born in Papua New Guinea and not Australia.

The solution in Papua New Guinea has been to create policy and programming for women's health that is aligned with reproductive health and safe motherhood. This has led to a predominantly biomedical approach to women's health and women's health issues are targeted as potentially treatable problems. Although reproductive health is a key factor in women's lives there is an absence of research on women's

health in Papua New Guinea that goes beyond epidemiological understandings, individual-based risk factors or a one dimensional view of health. The ways in which women's health is connected to other aspects of life receives little attention and remains unaddressed in the current health system.

This study supports a broadening of the biomedical framework underlying women's health research in PNG, and suggests a new direction for health policy, education, programming and advocacy. It prioritizes and recommends measures to address the links between the social and material conditions of women's lives in PNG and their poor physical and psychosocial health. Women's work and the physical burden of women's roles, marriage, the risk of violence and human rights abuses are examined as major risk factors for women's health. A focus on human rights and the implications for health is a challenging and fresh approach to women's health in Papua New Guinea and determines women's experiences as central to women's health.

The value of this research is also in its focus on the experiences of women at three different stages of the lifecycle; adolescence, adult and older women. We have learnt from the existing body of knowledge that health-related understandings and experiences at one stage of the lifecycle set the context for the next stage but gaps in the literature exist on these experiences as highlighted by women themselves. Furthermore, the needs and priorities of women at different stages of the lifecycle are diverse and it is important therefore to understand the implications for policy development and service provision.

The significance of this study is also in its focus on the experiences and meanings of women within their social and cultural context. This will enable a better understanding of health as women perceive and experience it, rather than pre-imposing categories on that experience which constrain its expression. This study is important in that it gives women the opportunity to highlight their meanings of health and (re)consider and act upon some of their health-related concerns. The recommendations therefore have significance for health workers, health educators and administrators in Papua New Guinea. Interview data from women and health workers give insights into the major gaps that exist between current service delivery



to women in PNG and the core health concerns of women. This research will give health providers a better understanding of women's perceived barriers to good health, and encourage them to see their vital role in the provision of an improved and equitable health service for women.

This study is also significant for policy makers in Papua New Guinea and donors, health professionals, administrators and NGO workers who are responsible for development programming. The research is designed to provide a useful and very real understanding of the perceptions, experiences and realities of women in their attempt to improve their health and wellbeing. It was designed to be applied in its approach so that its recommendations will be directed towards improving policy objectives, intersectoral collaboration and service provision strategies for young, adult and older rural women in PNG. The recommendations proposed allow those involved in policy development and implementation to be better informed about, and work towards overcoming, the social, cultural, psychological and economic constraints facing women in Papua New Guinea in their access to resources and services. It is hoped that a better understanding of rural women's health concepts and experiences within this context will mean higher priority is given to the real needs of women, as identified by women themselves. These findings are relevant for similar resource constrained developing countries where the status of women is low and women face health inequalities in their everyday lives.

From a personal perspective, I have had a very unique opportunity to learn about and experience, through living and working long term in PNG, the very real issues facing rural women. I am not only better placed to understand the complex nature of women's health, the link to women's low status and the challenges that women face in the attempt to overcome their subjugation but I understand the complexities and challenges involved with addressing these issues in the social, cultural, economic and political context of PNG. From a research perspective, the significance of this study translates into future research opportunities.

The complexities of women's concepts of health requires further examination, such as the diverse contextual details of what rural and urban women consider as good health, whether their perceptions change over time, in what direction and as a result

of which influences. The findings of this study could also contribute to the development of an action-orientated research agenda in women's health underpinned by a rights-based approach. This would mean a focus on empowerment in research and practice to give vulnerable women the opportunity to participate, mobilize resources, be more informed and develop their own strategies for social change.

## **8.6 Influence of the research journey**

This study gave me the opportunity gain unique insights into the life of rural women in Papua New Guinea. I was able to experience first hand many of the important values that define Melanesian societies, that of sharing, mutual obligation and collectivity. Through my observations, discussions and my own experiences of living in a rural area, I was also able to better grasp many of the social, cultural and economic constraints faced by many rural Papua New Guinean women. Yet despite the trying circumstances women were able laugh and tease each other, share stories and resources, offer or ask for support and empathize with each other's pain.

It is difficult to bridge the gap between insiders and outsiders. I had the fortune of being able to spend substantial time living and working in rural communities. I spent many hours talking with people, getting to know them personally, sharing stories, and eating local food (I learned to eat copious amounts of sago to my surprise). Purchasing food from the market everyday gave me the opportunity to socialize with many people, as did attending sports days and local celebrations. I learnt *tok pisin* which helped to reduce communication barriers and built trust. For this I thank my colleague and research assistant, who, without exception, would talk with me in *tok pisin* despite being able to converse fluently in English. The friendships I built and the local expertise that I depended on during the research, and more generally throughout my working life in Papua New Guinea have been fundamental to my cross-cultural learning and the depth of my experiences. These friends and colleagues helped me to cope with stressful encounters and deal with the demands of living in a rural area.

Priorities of rural women differ from traditional approaches which focus on women's reproductive health status. When I first began to conduct research on women's health

issues I had a focus on women's health in pregnancy (specifically related to malaria and anaemia in pregnancy) and the impact of socio-cultural beliefs (disease causality) and health-related behaviour on access to health services. It became very clear that this was only one small part of the health experience of women, which was embedded in the broader socio-cultural constructs of women's lives. It also gave me the opportunity to reflect on the types of research methodologies that are appropriate to use with rural women or other marginalized groups. Participatory, action research has the potential to engage those on the periphery and give participants space to perceive the need to change. Participants play an active part in the research and change process. Qualitative and participatory tools promote inclusiveness, interaction, shared learning and self-determination. The strength of action research is in the generation of solutions to practical problems. This is important if meaningful partnerships with women (and marginalized groups) are to be developed and women are empowered to engage with research and subsequent program design and delivery, monitoring and evaluation.

Throughout living and working in Papua New Guinea I have had the opportunity to become close to and learn from men and women working with communities in rural areas. They have become important role models for me, and more significantly, for other Papua New Guineans. Many have survived and learnt from great hardship and personal adversity. Others work with rural communities, in the field of health, law and justice or agriculture. They seek to understand the underlying issues, to take the time to listen, share stories and learn. They believe in the worth and capabilities of others and they work to create change within themselves, their families and communities. They believe in and work towards strengthening community cohesion and self-reliance through mobilization and empowerment. I have learnt that it is more than rhetoric. These people are an inspiration and I have learnt a lot from their humility, personal strengths and determination.

In this thesis I have presented a clear, simple narrative. It has been my intention to ensure the information is accessible and the recommendations are useful, realistic and of a practical nature. If anything, the research journey has taught me to value a meaningful process and to concentrate on the message. As a result the voices of women can be revealed in a way that reflects the contexts that they live.

## **8.7 Conclusion**

In the past decades, it has been widely recognized that women's health needs a holistic approach, based on the collaboration of many sectors (government and non-government) given the multi-causal nature of the problem (CSDH, 2008). Within this context, studies on women's own understandings of health in the circumstances of their lives play a vital role for the acceptability and quality of health programs for women, or as Polakoff and Gregory (2002, p.844) propose, what this means is that care providers must listen for the whole story, see behaviours in the context in which they were borne and are being lived, and acknowledge the circumstances and relationships that clients bring with them.

Advocates for men's health would suggest that there are inequities between men and women in access to health resources and would argue that men present an "at risk" population requiring more attention (Khoury & Weisman, 2002). This is based on the assumption that women have more opportunity than men to access the health system due to their own reproductive health needs or because they have brought a child for a health check. This thesis challenges this assumption and has attempted to take a different focus. In Papua New Guinea most public health actions on women's health have been justified as a means to control fertility and to improve child survival., It does not mean that by simply attending an antenatal clinic a Papua New Guinean woman will access a service that is appropriate, takes into account her health-related rights, or is delivered in a way that is sensitive to her real health needs. Many women, particularly rural women in Papua New Guinea, are not well served by existing programs that simply target one aspect of women's health.

In contemporary Papua New Guinea, where the status of women is lower than that of men, it is evident that the interaction between the determinants of women's health are having an impact on women's ability to access the resources necessary to protect and fulfil their right to health. A novel focus on socio-cultural research which includes an examination of the health and human rights link, could bring new insights into women's perceptions of their barriers to health. In order to make this link, women's health must be considered in a broader context which includes

women's real life situations. Women's choice of coping strategies, in connection with the material conditions of women's lives, the role of social relationships, gender-related discrimination and the psychosocial impact of oppression and exclusion, including violence against women, are important but greatly underrepresented topics in the socio-cultural and public health literature on women's health and health outcomes in Papua New Guinea. Women in Papua New Guinea are dying in unacceptable numbers because improving access to reproductive health care for women of childbearing age is only one part of advancing women's health. It is hoped that his thesis can stimulate further research in this field.

It is clear that all of these aspects can benefit much from the input of qualitative research and other participatory research methods. The aim of qualitative health research as applied to public health is to provide insights into women's lived experiences and through the use of a variety of methods avoid exploitative relationships and gender bias (Timmerman, 1999). Using qualitative and interpretive concepts, this thesis contributes information that can be used in women's health programs to tackle the specific problem of the gap between the real needs of women and the professionally defined objectives and activities of health providers. The challenge, on a different level, is to actually use the research results and to translate them into policy actions.

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## **Appendix 1**

**Copy of published article: *Beyond risk factors to lived experiences: young women's experiences of health in Papua New Guinea***

## ORIGINAL RESEARCH

# Beyond risk factors to lived experiences: young women's experiences of health in Papua New Guinea

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**Hinton RL, Earnest J**

**Beyond risk factors to lived experiences: young women's experiences of health in Papua New Guinea**  
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## A B S T R A C T

**Introduction:** The health of young women in rural Papua New Guinea (PNG) is often examined using individual-based risk factors which are decontextualized from the social and cultural relationships within which women's lives are embedded. Understanding the health meanings and perceptions of rural PNG women is important for bridging the gap between current health program delivery and the real needs of women. The objective of this study was to explore the health perceptions of rural PNG young women and to identify points in the lifespan where support may be required.

**Methods:** Thirty-three young women aged between 15 and 29 years were involved in the research. Multiple data collection methods were used within interpretive qualitative methodology and these included in-depth interviews, focus group discussions, photo narrative and ranking exercises. The study was conducted in a rural community in the Wosera district of the East Sepik Province of PNG from mid-2005 to early 2006. Following a community meeting and targeted awareness about the project to female youth, purposive and snowball sampling was used to recruit young women aged 15–24 years. The mean age of participants was 21 years. Single and married participants, unmarried mothers, school leavers and current school attendees were represented. Informed consent was obtained prior to the sharing of women's narratives. Data were categorized and analysed for emerging themes and cross checked with participants for verification.

**Results:** Young women viewed their health in the context of their social and cultural world and in terms of their wider life experiences. The main theme uncovered young women's strong desires for independence. Young women depended on their parents for emotional support and material possessions, and positive parental support provided young women with the opportunity



to move towards independence. Freedom from economic constraints was identified as important for autonomy, and having money was discussed as a requisite for good health. Young women discussed that building healthy relationships was integral to health. For single young women this was connected with having the freedom to spend time with friends and boyfriends. Married young women noted that their health was related to the quality of their marital and familial relationships and the level of support available to meet the demands of new roles and responsibilities.

**Conclusions:** The young women's narratives document the importance of the connection between the diverse health needs of young women and the social and cultural environment in which they live. The role of connectedness with family, friends and community in young women's lives is an important issue and can provide opportunities for the delivery of culturally appropriate support to young women in response to key transitional points in their health experiences. Health practitioners and policy-makers in PNG need to reconsider their assumptions underlying women's health programs and interventions in rural areas, and broaden their perspective of health to recognise the ways in which women's personal experiences influence health.

**Key words:** adolescent development, Papua New Guinea, peers/friends, qualitative research, women's health.

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## Introduction

Women in rural and remote settings face unique geographical, social economic and political challenges. They have diverse needs and health issues, which have historically been neglected by the healthcare system<sup>1-3</sup>. Studies in women's health have shown that health concerns the totality of women's experiences throughout the life span, with the implication that overall health includes, but is not only defined by, reproductive health<sup>4,5</sup>. The health concerns and life circumstances of women in different age cohorts are not the same, and as a result health systems work unevenly for women, failing to address specific needs across life spans, geographical circumstances and socio-cultural economic divisions<sup>6</sup>. Young and older women, for example, face age-group specific issues that constrain their access to appropriate care<sup>7</sup>. It is necessary to understand and provide support for women's health at critical stages in the life cycle when support may be required.

Globally epidemiological research has increased public awareness of risk factors associated with disease and has provided invaluable evidence in several areas of public health, for example: studies on intimate partner violence in multiple countries<sup>8</sup> and data from large scale mortality

studies in post-conflict nations<sup>9</sup>. However this is limited in its capacity to reveal a holistic picture of health, especially young women's health<sup>10</sup>. Attention is often focused on individual-based risk factors and epidemiological studies are decontextualized from the social relationships within which these risk factors occur<sup>11,12</sup>. In addition, the studies do not portray the social, material and structural factors that influence risk behaviours and ultimately health.

### *Young women in rural Papua New Guinea*

Young women's health in Papua New Guinea (PNG) is synonymous with discussions about HIV transmission and reproductive health. Current statistics reveal that the 15–24 year age group make up over 50% of the HIV prevalence, with females in this age group having an estimated prevalence of 0.9%<sup>13,14</sup>. As a result, reproductive and sexual health programs respond to adolescent health in relation to specific behavioural, social and environmental 'risk factors' and HIV and sexually transmitted infection transmission risks. Young women are constructed as a risk group and this has led to stigmatization, scapegoating while it overlooks differences among young women as a group<sup>15</sup>. There is also little examination of how these risks and relationships might be historically and economically driven processes that constrain individual agency and are rooted in a life of





nutritional deficiency, illness burdens, heavy workloads, poverty, gender discrimination and unequal access to educational and other opportunities<sup>16,17</sup>. Although health related behaviour is to some extent within the control of an individual young woman, many of the social determinants of health are not, and her agency is constrained by the situations and statuses that are conferred on her<sup>18</sup>.

## ***Risk factors and young women in Papua New Guinea***

Women in PNG face unequal opportunities in education, income generation and access to economic resources and property<sup>19</sup>. Widespread and entrenched gender inequity leaves girls particularly vulnerable to abuse, exploitation and violence. Intimate partner violence has reached unacceptable levels<sup>19</sup> and regional surveys have revealed that 67% of rural women have experienced violence from a spouse or intimate partner<sup>20,21</sup>. More recently the Government of PNG stated that 'young women all over the country are at high risk of rape, gang rape and other forms of violent sexual assault'<sup>22</sup>. Female literacy is only 46% and only 6% of the female rural population reach an education level of grade 10 or above<sup>23</sup>. The low status of women perpetuates patterns of early marriage and frequent childbearing, seen in the total fertility rate of 4.0 (women 15–49 years), one of the highest in the Pacific<sup>14</sup>. Early marriage increases a woman's vulnerability, and disrupts educational opportunities and social ties. The prevalence and social acceptability of violence against women are major factors contributing to the poor health of young women in PNG<sup>19</sup>.

## ***The research question – understanding women's health beyond risk factors***

It is easy to see solutions as either medical or matters of health education (M Macintyre; pers. comm., 2009). Problems specific to women's health are complex and not attributable to either lack of knowledge or absence of services. Instead she argues that the health status of women reflects the complex and changing social and structural conditions of women's lives. Little is known about rural

PNG women's perceptions of their health needs, and even less is known about women's health issues across the lifespan. This is a serious issue in a country where over 80% of the population lives in a rural area. In order to provide an alternative to the current biomedical discourse on rural young women's health in PNG it was necessary to understand the health-related experiences of young women, as shared and narrated by the women themselves, and to examine health as it is situated within the socio-cultural context of women's lives.

## ***Aim and objectives***

The overarching aim of the larger study of which this article is one aspect was to undertake an ethnographic assessment of women's health within the socio-historical context of PNG to: (i) identify if there are critical points in the lifespan affecting positive change in the health status of women; and (ii) ascertain if the gap between the perceptions of service providers and the real needs of women can be bridged. The objectives of this article were to examine young women's perceptions of health and health-related experiences using a gender analytic framework, and to identify priority areas for public service interventions.

## **Method**

### ***Use of the qualitative approach***

This study used rapid ethnographic assessment, a modification of traditional ethnography which accommodated a combination of qualitative and interpretive methods and a shortened period of time in the field. Rapid ethnographic assessment and interpretive methods enable researchers to learn about what is happening to individuals and groups of people within a specific setting, and to gain meaningful contextual data by paying necessary attention to social and economic factors, cultural practices and local ecological circumstances<sup>24</sup>. The methods create space for shared dialogue between researcher and participant<sup>25</sup>. Ten in-depth interviews (IDI), 2 ranking exercises (RE), 2 focus



group discussions (FGD) and 2 photo narrative (PN) exercises were conducted. Questions centered on young women's personal narratives and perspectives of their health-related concerns, with particular attention to understanding these perspectives within the social context.

In FGD and IDI, open-ended questions sensitive to the context were used to reveal what being healthy meant to young women:

1. Tell me about everyday life. What is a woman's life like here?
2. When you say are healthy what do you mean?
3. What can you do to stay healthy? What is the most important thing you do to stay healthy?
4. Do you often think about your health? If no, what brings 'health' to mind? If yes, what makes you think about it?
5. What are the (health) problems women (your age) face here? What problems are worse than others? How?
6. Does your mother face the same problems as you? If no, how are they different?
7. Is there something you do to overcome the problem of (name problem)? If no, how do you think this problem could be overcome?

Photo narratives added an extra dimension to focus group discussions<sup>26</sup>, with photos of women at different stages of their lives (child, adolescent adult) used to stimulate discussion. Participants were shown pictures of women from a similar rural PNG context and undertaking specific tasks or responsibilities (eg a young woman selling food at the market, a mother sitting with her children). Participants were asked to describe each photo, who was in it and what she was doing. They were asked to think of some of the girls/women of a similar age in their village and to consider what their life might be like. Further questions relating to the photo included, what sort of (health) problems might she have and what do you suggest could be done to help her? Participants were also asked to consider what the girl's/woman's hopes might be for the future. Discussions

also attempted to address issues of resilience, hope, aspirations, healing and empowerment.

Ranking and scoring exercises provided a useful means for young women to prioritize, compare and discuss their main health issues. A maximum of 10 health problems were identified collectively. Each issue was represented by an agreed item from the local setting, placed in a row on the ground. For example violence against women was represented by a stick. Each health issue was ranked using pebbles, and attributed various numerical values (free-scoring) that indicated relative importance. Values ranged from 5 (most important issues) to 1 (least important). Emphasis was put on group interaction and consensus regarding identified health problems. Most of the young women who participated in an FGD or PN exercise participated in an RE. This provided the opportunity to gain feedback, and cross-check and validate some of the preliminary findings.

The first author (RH) carried out the majority of discussions in *tok pisin* (Melanesian Pidgin), the local lingua franca, with the assistance of a local research assistant. The local assistant was from the area and had been working as a health researcher at the study site for several years. Several young women chose to speak their first language (*Ndu*) and in these cases the discussion was facilitated by the research assistant with the support of a local field assistant. The research assistant assisted in the interpretation of cultural understanding and meanings, and emerging themes were discussed with the local field assistant. Cultural interpreters increased reliability of the data collected as they clarified terms and local nuances, assisted the first author with translations where needed, conducted 'member checks' with key informants, and were able to respond to participants' questions in a meaningful and sensitive way<sup>27</sup>.

## ***The study site***

The research site was a village in the Wosera District, East Sepik Province of PNG. The research was carried out from mid-2005 to February 2006 and was part of a larger study



examining rural women's health within the context of women's lives at critical stages in the life cycle.

The Wosera District is part of Abelam territory, an ethnolinguistic group occupying an area between the southern foothills of the Torricelli Range and the Sepik River. Abelam clans are patrilineal kin groups and several clans are represented within each village<sup>28</sup>. In the Wosera it is common for women to perform the majority of daily domestic duties and subsistence work. Women's health and social development statistics are poor due to entrenched inequalities, multiple role responsibilities and because the status of women is lower than that of men. The payment of a 'brideprice' in which a woman's fertility and labour are acquired from her father, entails husbandly authority over a woman<sup>19</sup> (M Macintyre; pers. data, 2009). Of the rural population in the East Sepik in 2000 only 43% of women were literate<sup>23</sup>. There is a heavy reliance on subsistence production for household consumption. Cash earning opportunities are limited, evidenced by low per capita incomes<sup>29-31</sup>. In 2004, the antenatal coverage of five health centres in the Wosera was 48%<sup>32</sup>, below the 2006 national average of 58%<sup>13</sup>.

## ***Participant recruitment***

Snowball and purposive sampling were predominantly used to recruit participants. Women were identified following a community information session and by word of mouth. Recruiting and gaining access to young women was initially challenging because many young women did not attend the community meeting. With the help of a local field assistant young women were targeted specifically, the nature of the study explained and existing misunderstandings clarified.

Single and married participants, unmarried mothers, school leavers and current school attendees were approached and made aware of the study. The snowball recruitment technique allowed for this diversity and the four-month study period ensured there was ample time for participants to talk of their experience with others and encourage some of the more uncertain young women to take part.

Although the study classified young adults as 18–24 years, it became more relevant to rely on social relationships and groupings, rather than actual ages. Self-identification and social acceptance underpinned the sampling process and six women under the age of 18 and six women over the age of 24 self-classified as a young adult. Oral parental consent was obtained by 8 participants under the age of 18. There was an even spread of the socio-demographic groups of young women who participated in each method. For example, of the 2 FGD, 1 was conducted with young women who were married (with and without children) and aged mid- to late 20s, while the second was conducted with single women in their late teens, either currently attending school or no longer enrolled. Eight of the 10 IDI were conducted with single women, one of whom had a child. Three young participants were currently in high school.

## ***Ethical considerations***

The participants knew the purpose of the study before discussions took place and were assured of confidentiality. Consent was given orally and participants were not asked to sign a consent form. This was less obtrusive and also took into account high illiteracy levels. This informal process contributed to the establishment of rapport and trust with participants. Ethical approval was obtained in accordance with the requirements of Curtin University's Human Ethics Committee and the PNG Medical Research Advisory Council.

The authors were also aware of their own positions at all times. The first author who undertook the research has lived and worked for several years in PNG. She is sensitive to the social setting and understands the importance of presenting narratives that reveal women's voices and are embedded in landscapes in which they live. The second author is from the developing world and works extensively with participatory and empowerment methodologies.



## Data analysis

All IDI, PN exercises and FGD were audio-taped and transcribed verbatim for analysis. The process of analysis involved a deep immersion in the collected data. The first author and local research assistant read, re-read and discussed participants' accounts for emerging themes and issues requiring further questioning<sup>33</sup>. From emerging themes, codes were generated and applied to segments of transcribed data to identify common categories of importance as well as unanticipated findings. The emerging themes were also communicated to the local field assistant for her consideration, input and cultural contextualisation. The software program Atlas-ti v 4.1 (Atlas-ti; Germany; <http://www.atlasti.com/>) was used to manage the data analysis process<sup>34</sup>.

## Results

### Socio-demographic characteristics

The socio-demographic characteristics of the sample are presented (Table 1). Thirty-three young women participated in the study and ranged in age from 15 to 29 years. Participants had an average education level of grade 6. Four young women were enrolled in grade 6 or above during the study period. One-third of the participants ( $n = 11$ ) were married and nine of these young women had one or more child. Three of the single young women had a child. Five of the 11 married young women had a village of origin outside the study site; two were from neighboring villages, two from a village within 1 hour's walk and one from another province, accessible only by air or sea. This diversity offered interesting insights and nuances into the ways young women's health needs were framed and prioritized in the context of their marital status and associated roles and responsibilities.

### Young women's definitions of health

Young women typically spoke about 'being healthy' by drawing on descriptions from the social and material

circumstances of their lives and their daily activities. Young women expressed the need to 'have money' to be healthy, identified during RE as their most pressing health priority and a point discussed at length by all young women.

*Angela: If I don't have kerosene I will worry. When I don't have money I find it really hard. If I don't have salt or kerosene, I will sit down and think a lot. How will I get money to buy these things? How will I look after my family? Women have a lot of problems finding money. (FGD, 29 years)*

The nature of women's social relationships and access to social support to mediate workload demands and economic constraints also determined good health, and discussions centered on a desire for cooperative and caring spousal, friendship and kinship relations.

*Leslie: I'm a young woman and I want to do my own thing. If I want to collect water, cook or go to the garden and harvest vegetables or cut firewood, I will do it. If my parents or in-laws force me then I won't want to do it. I have learnt how to do it already and so I do it when I see there is a need. If they press me to do chores I tell them that I'm not a child, I'm a grown woman. Then if others hear what they say to me they will think that I am disobedient and then they might ruin my name and say that I don't like to work. (PN, 29 years)*

All young women expressed similar sentiments for independence. However a desire for increased independence was mediated by their dependence on parental and social support to meet their personal and material needs. Young women's discussions of independence highlighted 3 interrelated sub-themes: (i) the balance between dependence and independence; (ii) the value of financial dependence; and (iii) building healthy relationships. The following quote by Sylvia provides a good illustration of the interplay between the 3 themes, and each is examined in greater detail in the discussion below.



**Table 1: Demographic characteristics of 33 young adult women participants**

Characteristic	Value
Age (years) <sup>†</sup>	20.9 ± 4.86
Educational status - <i>n</i> (%)	
Never schooled	2 (6)
1–6 years of schooling	15 (45.4)
>6 years of schooling	16 (48.4)
Marital status - <i>n</i> (%)	
Unmarried	22 (66.6)
Married	11 (33.3)
No. women with ≥ 1 child - <i>n</i> (%)	12 (36.3)

<sup>†</sup>One value missing.

*I live with my parents and they don't tell me off. They both give me money. When I want to go around with my friends they give me money. Sometimes when I want to go out they get cross. But generally, I have a good life. But if I go out with my group of girl friends at night my parents do get cross. (IDI, 19 years)*

### ***The balance between dependence and independence***

A woman's workload was perceived to be unchanging and physically demanding. It involved water collection; the weeding, planting and harvesting of crops; the sourcing and cutting of fire wood; food preparation and cooking; and the washing of clothes and cooking utensils in the river. Unlike adult women or young married women, young women who lived with their parents had fewer workload responsibilities, although most were expected to help their mothers with domestic duties and the care of younger siblings. Amy claimed she had the freedom to choose whether to work or not:

*When it comes to sago for example, sometimes I help my mother to harvest it, but sometimes I can't be bothered so I just stay at home. (IDI, 19 years)*

All single young women discussed that despite depending on their parents for care and emotional support, they wanted to establish themselves as independent and separate beings

from their parents. Young women recognised their security was synonymous with their parents' care. They wanted to be provided for, fairly treated and assigned few responsibilities by their parents, which in turn would give them the opportunity to seek other pastimes. They did not want to seize independence by rebellion but by negotiating with their parents for greater latitude and freedom, as Michelle explained, 'I do a lot of the work, I help my parents and then in return my parents give me money'. Their independence and desire for autonomy therefore was conditional on parental acquiescence. Everlyn expressed the link clearly:

*Sometimes we help our mothers to cook. When they are tired we cook. Or if our mothers cook we can do other chores for them. And then they don't get angry and they are happy with us. Then we get on well with our parents and they give us money if we ask for it and they let us go out. (FGD, 22 years)*

Parental provision of social and material support would show a single young woman she was respected and cared for, and the result would be compliance and obedience. If a young woman felt neglected by her parents, she was tingting bai bagarap (unable to think straight) and in desperation could seek alternative avenues of support from outside the family. Young women believed this could lead to high risk behaviour, such as substance abuse and transactional sex, and exploitative personal relationships. Parental care and support was also valued by married young women. A mother





was required to prepare her daughter for marriage by teaching her the fundamental domestic skills to manage her own household and family.

The act of engaging in a struggle between dependence and independence has been identified as a necessary developmental step towards adulthood<sup>10</sup>, but for single adolescent mothers, the absence of parental emotional and practical support could have serious mental and physical consequences. Two of the three single adolescent mothers were particularly vocal about the independence they sought from their parents. Adolescent mothers expressed their anger and frustration at the treatment they received from their parents, and the degree to which their life had changed for the worse. They faced the early cessation of education, abandonment by their boyfriends and a stigmatized child. As with the stigma associated with HIV transmission in PNG, there was a pervasive retributive logic that laid the blame on pregnant adolescents because they had defied traditional customs<sup>35</sup>. They were forced to take on multiple workload tasks and, because the young women were not in formalized relationships such as marriage, they had limited opportunities for help and support.

*Michelle: If my brothers can help me to build a house my life will be good as I'll have my own house. Like, now I live with my parents I face a lot of problems. If I had my own house I'd be in a good position. I'd have my own garden and I would go to the market and earn some money and I'd be able to provide for myself. (IDI, 21 years)*

These participants also described considerable emotional and physical violence in their lives, as is evidenced by Elsie's account:

*I don't respond when he [father] yells. If I talk back then I will get hit and be in a lot of pain. So I just close my mouth and let him yell at me. That's what I do, I don't talk back. (PN, 21 years)*

### *The value of education and financial independence*

During interview, all but one young woman discussed money in relation to their autonomy and as a requisite for good health. The search for independence by having access to money was expressed in different ways. The economic needs of married young women were directly related to their new role and accessing the essentials necessary to maintain a household: food, kerosene, soap, clothing and their children's school fees.

Single young women spoke about how having money created opportunities to connect with friends, family and peers, to access market resources, or to buy and share items such as betel nut and cigarettes. The connection between money and the opportunity to purchase items according to the standards set by their peers ran through several interviews. It was important to keep up with the latest style of dress, or to accessorize with hair products and nail polish, and personal items such as clothing, laundry and body soap were a constant issue of concern. Jane explained that she wanted to have the means 'to look after myself.'

*If you have money you will think about buying good food, spending time with friends at the market. Money is our support. If I have money I will be healthy, I'll feel happy. If I go to school I know that I will have everything I need. (IDI, 19 years)*

The perceived social and economic opportunities that a completed high-school (grade 10) or secondary (grade 12) education offered young women were seen as integral to health. Education was identified as a key strategy to improve current and future wellbeing and to create socioeconomic opportunities. Eight of the single participants, however, discussed the precarious nature of their financial dependence on parents to continue their education. Only 4 of the 8 were currently enrolled in some form of education, with the remaining 4 excluded, mainly due to high education costs and the parental preference for investing in male education.



Access to secondary and tertiary education is limited, and even where access is not a problem, the quality of the education provided is often low. Furthermore, an increasing number of youths leave school after completing grades 6, 8, 10 and 12, and cannot find formal employment either in rural or urban areas due to a lack of experience or qualification<sup>36</sup>.

### ***Building healthy relationships***

Another aspect of the struggle for independence involved young women having the freedom to develop healthy relationships with their female and male friends. Young women described the value of being part of a wider support network of trusted allies who were experiencing the same struggles and concerns. Participants talked about the strong ties they shared with their friends, and that there was a strong correlation between spending time with friends and their sense of happiness.

*Sylvia: When I go out with my friends I feel healthy, I feel happy. If I can't go out and have to stay in the house I feel fed up. (IDI, 19 years)*

Being happy was interrelated with all three of the themes discussed, and was often heard in conjunction with *mi fri long...* (I'm free to...). Happiness was associated with autonomy - being free to socialize, free from economic constraints and free from parental influence.

*Sue: When I spend time with my friends, I feel really happy. We tell stories about ourselves, we talk to each other, and I feel really happy. (IDI, 18 years)*

Many single young women stressed the importance of spending time with their boyfriend. Socializing with an unrelated young man was regarded as an undesirable modern practice by parents and male siblings, as was wearing revealing modern clothing, drinking alcohol, smoking marijuana or going to a 'six to six' disco party. Young women avoided gossip, criticism and cultural expectations through secrecy, which allowed them to have boyfriends

without getting caught<sup>37</sup>. Open affairs were likely to result in a young woman being beaten by her male kin because of the shame of her behavior, which reflected badly on them. Although the exercise of these meetings was often difficult, with go-betweens used to pass messages, young women made a clear link between having the opportunity to nurture an intimate relationship and a sense of wellbeing. This link was expressed as a necessity, *mi mas lukim boi fren blong mi na mi bai pilim hamamas* (I must see my boyfriend and then I will feel happy), and it was one aspect of their desire for independence that was most difficult to achieve.

Young women were aware that the pursuit of romantic courtship had its risks. Fear of pregnancy was a common health-related concern in young women's accounts of their relationships with young men. As they negotiated the tension between desire for romance, companionship and assessing a potential husband, and the fear of stigma if discovered, the hidden status of the relationship ensured a lack of access to information and contraception<sup>13</sup>. Young unmarried women in this study were frequently refused family planning information or access to contraception by health workers and volunteers engaged in community-based reproductive and sexual health education activities. Several health workers and volunteers justified their actions to the first author explaining that they did not want to facilitate the promiscuity and sexual activity of young women outside the confines of the marital relationship.

Young married women's struggles to build healthy relationships were discussed in terms of the types of relationships they had with their husband, kin and in-laws, and the different avenues of support available to them in order to meet the demands of their multiple responsibilities. In spite of her own desire to be cared for, Doreen now had the full responsibilities of an adult and she spoke about her need to be supported in this new role:

*If we work together, if my husband follows me to the sago garden and we do the work together, or he looks after the baby while I do the work, when we come*



*back to the village we get on together well. I feel happy. (IDI, 25 years)*

All married young women recognized that their physical and emotional wellbeing could be enhanced by having a 'good' husband. This meant a husband who was non-violent and did not seek to control his wife's movements and socialization.

*Beryl: A big thing is when we want to go a play sport or socialize with friends, our husbands stop us and we don't feel that this is a good attitude. We ask ourselves, why do they stop us from doing what we want to do? That's what we think about and we worry about it. It's a big thing for us. (RE, 26 years)*

*Angela: Sometimes men hit their wives. They make us bleed. They use their knives on us and beat us badly. Or some beat their wives with cane. A lot of problems occur because of this and we find it hard to respond. But we do consider leaving our husbands. (RE, 29 years)*

Young women desired a man who listened to the requests of his wife, assisted in childcare and other workload activities, and who supported the family financially by sharing or saving any earnings. Married women ranked a supportive husband as their second most important health concern. Anna explained that having a supportive husband was an aspect of life that was integral for creating a sense of wellbeing.

*From my perspective, I feel really good when my husband helps me and we work together. I feel encouraged and I think, because of his help, I am able to have some time to rest in the village. (IDI, 21 years)*

In PNG a husband who worked regularly in the gardens and assisted with childcare was not typical, however, and in order to cope with the new roles and responsibilities associated with marriage, most of the young women still sought support from their maternal family. Although young

woman expressed a desire for independence that could be achieved by marrying and living away from the familial household, they felt that residing in a different province, district and even village, could be an isolating and demanding experience in terms of their daily life and existence with no kin to support them. However, as the marriages of the young women in the present study were contracted between partners in different sections of the same village or neighboring village, most were never far from their natal homes<sup>38</sup>. This gave Anna much needed access to social, material, emotional and physical support at a challenging stage of her life cycle.:

*My mother comes and visits me here. Anything I need she gives me, like sago, vegetables, bananas. She goes and gets it from her garden and gives it to me. (IDI, 21 years)*

## Discussion

### *Understanding the links between health and lived experiences*

**Good health - a social and cultural experience:** Good health in rural PNG, as voiced by the young women of this study, is a social and cultural experience, not an isolated or individual condition. All the young women viewed health in the context of their social world. The meaning of health was always embedded in descriptions of women's connection with others, the demands of their gender roles and responsibilities, and their capacity to meet pressing economic and material concerns, and motivated by their efforts at independence. There are similarities between the descriptions of health by the women in this study and those mentioned by women in different cultural contexts, such as Cameroon<sup>39</sup>, United Arab Emirates<sup>3</sup>, Wales<sup>40</sup> and Ecuador<sup>41</sup>. The voices and narratives of young women in this study have drawn similar attention to the relationship of health to wider life experiences. It is these narratives that are absent in the current political and public health discourse in PNG.





Contrary to the current discourse on young women's health in PNG that is focused on risk factors and behavioural determinants of sexual and reproductive health, young women's health needs were articulated in response to what Bannister and Schreiber term 'struggles for independence' in daily life, and their connectedness to others most important and closest to them<sup>10</sup>. Thus, the current approach that addresses risk behaviour has the potential to be perceived as alien and irrelevant to the real life experiences of adolescent women<sup>10</sup>.

### ***Connectedness and good adolescent health***

The link between connectedness and good adolescent health has been extensively considered and documented<sup>41-44</sup>. Being well connected to significant other persons (or institutions) can provide a sense of belonging, an absence of loneliness and a perceived bond with socialization agents, and is protective against problematic behaviour and poor health outcomes. If young people have mutually beneficial relations with the people and institutions of their social world they have a greater chance of a future marked by positive contributions to self, family, community and civil society<sup>43</sup>.

The young women in this study expressed their desire to be connected to others, their family and peer groups. Connectedness to the school institution and school friends was discussed as important for good health for some young women, and supports other studies that have examined school connectedness as a protective factor for adolescent health<sup>45,46</sup>. Happiness was associated with affectionate and communicative interaction and supportive and fair parenting. In the domestic environment this meant having parents that did not intrude on, exploit or manipulate a young woman's independent self<sup>43</sup>.

### ***Developing healthy relationships with boyfriends and in marriage***

Participants romanticized and favoured love-match marriages to the traditional practice of kin-arranged or preferred marriage. These relationships were discussed in

terms of respect and cooperation, as well as psychological intimacy. The social and cultural context of these young women's lives, however, impacted on their ability to develop these types of relationships. Young women, for example, took great care to hide their pre-marital relationships from male siblings and parents, as well as from public view. The social and emotional consequences of premarital pregnancy have been documented<sup>47</sup>, and as evidenced by the accounts of the young women in this study, manifest in low self-esteem, feelings of social isolation, helplessness and powerlessness. It is now well known that being abandoned or stigmatized can force women into casual and commercial forms of sexual networking, adding extra health and social burdens<sup>48</sup>.

Married participants expressed frustration that their expectation of marriage as companionate and supportive was often not met. Respondents' descriptions highlight the importance of understanding the effect of gender expectations on young women's lives, their growing economic responsibilities, as well as the new responsibility for the primary care of their families<sup>49</sup>. The married women in this study sought healthy and supportive relationships with their own kin, husband and in-laws in response to their gendered roles, financial insecurity and heavy workloads.

### ***Health and the socioeconomic status of women***

The link between health and the socioeconomic status of women is receiving more attention<sup>50,51,41</sup>. The circumstances of want created an oppressiveness in young women's lives and they struggled to meet their basic needs on severely restricted budgets. Continued access to education was tenuous for some and impossible for most. Unmarried mothers were particularly disadvantaged without a husband to assist in child rearing, subsistence labor or through paid work. Some security was felt in the support young married women received living close to their natal family.



## Conclusion

This study has shown that rural young women have distinct health-related perceptions and experiences related to the social, economic and cultural circumstances of their lives. The results document that health is related to the gendered roles and responsibilities of women within their families and communities, and not limited to the reproductive cycle and child-bearing. These findings are consistent with a recent study of Indigenous adolescents in Australia that shows vulnerabilities to ill-health are embedded in the social and cultural context, and related to educational constraints, drugs and alcohol and racial discrimination<sup>52</sup>.

### *Recommendations*

To deliver effective health care, we argue that is not enough to focus only on reproductive and maternal health. It is essential that there is an examination of the challenges facing young women at various phases of their lives – when they are single, married or single mothers. The WHO strategic approach to improving reproductive health policies and programs provides a useful framework for the development of evidence-based policymaking for women's health in PNG<sup>53</sup>. This three-stage approach – strategic assessment and action research; identifying and addressing management, technical and socio-cultural resource issues that affect service delivery and quality of care; and participatory and collaborative decision-making among a variety of stakeholders – provides the scope to assess and manage women's health within a broader context of health, to explore viable program alternatives and to encourage multidisciplinary stakeholder involvement. The methodology, with its systems framework and participatory process, has proven useful for assisting countries such as Bolivia and Ethiopia in the process of identifying health priorities and in the design and strengthening of health policies and programs.

The study revealed the intricacies and complexities of the lives of young women, their agency and struggle for

independence against entrenched communal and institutional practices. There is also the need to evaluate the impact of the challenges faced on self-esteem, resilience, pro-social behaviors such as sharing, generosity and helping and problem behaviour avoidance – aspects that build agency<sup>45</sup>. Further exploration is required to understand the ways in which young women prioritize different relationships and health at various points in their lives.

Policymakers and practitioners should be required to identify and respond to key factors in women's health experiences<sup>54</sup>. Given the role of connectedness, for example, in young women's lives there is a need to further examine and communicate a small number of basic conditions parents, teachers, peers, health educators should attempt to facilitate in their relationships with young women<sup>43</sup>. This provides the opportunity to enhance parenting and teacher training skills in support of adolescent autonomy, respect for individuality, mutual trust and respect and positive discipline. Peers and family members could also be trained as mentors to act as role models and to motivate and spend time with young women. This could enhance the established mentor-type relationships that some young women experienced with key family members. Mohajer et al. noted that mentoring programs can provide a medium for family members to engage with youth, build their self-esteem and empower young people in a culturally acceptable way<sup>52</sup>.

An alternative approach to women's health would be to value women's own accounts of their health, and to examine gender roles and responsibilities as they affect health. To ensure a better balance between the treatment of disease and infirmity, and health promotion and prevention efforts, greater consideration must be given to the many factors beyond clinical health services that contribute to rural women's health. Health professionals in PNG must take up the challenge to reshape their understanding of how young women's experiences and life circumstances influence their health and wellbeing.



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## **Appendix II**

**Copy of published article: *The right to health: Overcoming inequalities and barriers to women's health in Papua New Guinea***



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## The right to health: Overcoming inequalities and barriers to women's health in Papua New Guinea

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### SYNOPSIS

Few attempts have been made to examine women's health in Papua New Guinea using a human rights framework that puts women and their experiences with fear, abuse, oppression and discrimination, at the core of women's health. This article describes the findings of a qualitative study that examined the key determinants of women's poor health and the level of access to appropriate health care in relation to the right to health. Three main themes emerged as significant barriers to health; 1) violence 2) heavy workload and lack of economic opportunities 3) limited use of health services. The findings show that women's familial, socioeconomic status and productive roles intertwine to threaten their right to health. These findings should challenge health practitioners and policy makers in Papua New Guinea to put questions of power, resources, vulnerability and discrimination at the core of women's health programming.

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### Introduction

The right to the highest attainable standard of health is among a host of interdependent and indivisible rights guaranteed to all human beings under international treaties. The right to health is closely related to and dependent on other human rights that are determinants of health, including the right to life, liberty and security of person, the right to adequate food, housing and social security and the right to an education. Individuals rarely suffer neglect or violation of one right in isolation (Gruskin, Mills & Tarantola, 2007). The human rights aspects of health and the connection between the right to health and economic and social conditions was clarified in the International Covenant on Economic, Social and Cultural Rights ratified in 1976 and Article 12 asserts that "it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (ICESCR, 1976). This included measures to improve medical care together with a focus on health-enabling factors outside the medical realm (Solar & Irwin, 2007).

#### *Examining the right to health*

Multiple human rights documents which include the International Covenant on Civil and Political Rights (1976),

Convention against All Forms of Discrimination against Women (1981), Convention on All Forms of Racial Discrimination (1969) and Convention on the Rights of the Child (1990), promote and protect human rights as a prerequisite to health and well-being. Every government is now party to at least one treaty incorporating the right to health. The right to the highest attainable standard of health makes governments responsible for the prevention, treatment and control of diseases and for the progressive correcting of conditions that may impede the realisation of the right to health (Braveman & Gruskin, 2003).

The determinants of health, stemming from underlying social stratification, and the level of access to affordable, appropriate and quality health care contribute to a person's ability to achieve the highest attainable standard of health. Globally, in most countries, there are those who enjoy a higher standard of health and quality of services and those who, due to a range of, civil, political, economic, social and cultural factors are more vulnerable to ill-health and have inadequate access to health-related services. Research has documented a relationship between health inequalities and inequalities in income, education, occupational status and employment status (Bruner & Marmot, 2006; Pietilä & Rytönen, 2008; Siegrist & Theorell, 2006) and health-related mediators of inequality and inequity include health behaviours, psychosocial resources, coping

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strategies and social support (Denton, Prus & Walters, 2004; Moss, 2002). Of critical importance is the recognition of gender as a key determinant of health inequities. While many of the social determinants of health are the same for women and men, because of the interaction of these determinants with gender, women and men experience health and illness differently (Cohen, 1998).

#### *Where do women's rights fit?*

The Cairo International Conference on Population and Development (1994) and the Platform for Action of the Fourth World Conference on Women in Beijing (1995) were instrumental in solidifying the link between human rights and women's health, a link reinforced in international consensus documents (Gruskin & Tarantola, 2005). The Beijing report endorsed an approach to women's health to improve the status of women and women's empowerment through education, employment and involvement in social development. Significant to this changing model of women's health was the goal of improving human rights for women and targeting the discrimination and gender inequalities that underlie women's health, including a focus on violence against women and increasing access to justice (Meleis & Im, 2002; Moss, 2002). There was a move away from seeing women's health as a biological problem that could be addressed solely through improved medical technologies, to a holistic and contextual model that recognised health as a product of the same forces that structured a woman's relationship to the physical and social world around her and could be addressed through social policies, programmes and activist movements (Freedman, 1999a). The commitments to the advancement of women given at Beijing and the recognition of women's human rights spelled out in the Convention against All Forms of Discrimination against Women (CEDAW) and other human rights instruments since Beijing have not been realised in Papua New Guinea (Amnesty International, 2006). Women living in poverty continue to experience persistent inequalities and inequities and have little formal or informal power to effect structural change to improve their health. Unless international commitments and national policy documents are revisited and monitored carefully and the information used to hold governments to account, progress toward gender equality will be constrained and the urgent needs of women will continue to be ignored (Meleis, 2005).

#### *Recognising the right to health in PNG*

Papua New Guinea (PNG) has a high level of aid dependency (Corner, 2008). Australia wields enormous influence over PNG because of the two countries' proximity, colonial history and Australia is Papua New Guinea's largest foreign donor. The Australian Government will spend AUD \$377 million in Papua New Guinea in 2009–2010 (AusAID, 2009). The size of this assistance alone allows the Australian Agency for International Development (AusAID) to dominate and monopolise the development and political discourse. Despite the severity of human rights abuses in PNG, the Australian government does not consistently press the government of PNG for improved human rights or integrate

human rights in discussions of poverty reduction and sustainable development strategies (Asian Centre for Human Rights, 2008).

Despite an active women's rights movement in the Pacific region, women's issues are barely represented in national politics and government policies. Women in Papua New Guinea are excluded from decision-making at all levels, and the political landscape is dominated by men. "Traditional" culture and customary practice is invoked to justify gender discrimination, subordination and disqualification from political, bureaucratic and modern economic spheres (Macintyre, 2000). Two major studies on human rights in Papua New Guinea show widespread and systemic patterns of abuse perpetuated by police and endemic violence against women and children by male relatives and both known and unknown perpetrators (Amnesty International, 2006; Human Rights Watch, 2005). The threat of gender-based violence, particularly sexual violence, impacts on a woman's ability to move freely in the community, to use public transport, to access health and education services, and to travel to market or to the workplace (Amnesty International, 2006). Researchers have shown that women in Papua New Guinea experience high levels of intimate partner violence (Bradley, 1994; Lewis, Maruia & Walker, 2008; Toft, 1986). These women are denied the right to access justice, to receive reparation or to see their perpetrator punished. Widespread violence and abuse, together with a weak health system, high levels of poverty and socioeconomic inequity limits Papua New Guinea's ability to meet its commitment to the Millennium Development Goals (MDGs) and contributes to women's poor health indicators.

Maternal mortality has gained global prominence as a human rights issue, indeed the commitment to improve maternal health that was made in the Millennium Declaration has become a central platform to international development efforts. In Papua New Guinea women's health statistics are a pressing public-health concern. The life expectancy of women is estimated to be 61 years (World Health Organisation [WHO], 2006). Women's maternal mortality rates in PNG are the highest in the Pacific region (870/100,000), compared with 236/100,000 in the Solomon Islands and 50/100,000 in Fiji (World Health Organisation/Western Pacific Regional Office [WHO/WPRO], 2008). A woman from Papua New Guinea is 200 times more likely to die in childbirth than a woman in Australia (4/100,000). Obstetric causes were the fifth leading cause of morbidity and inpatient care between the years 2000 and 2004, with a prevalence of 266/100,000 (WHO/WPRO, 2008).

A woman's right to health is not just about access to maternal and reproductive health care. Women in Papua New Guinea are dying at high rates because of chronic and entrenched inequalities, because women's health is not valued in itself and the status of women is lower than that of men (Macintyre, n.d.). Few attempts have been made to examine women's health in Papua New Guinea using a human rights framework that puts women and their experiences with fear, abuse, oppression and discrimination at the core of women's health. This entails an examination of women's health within the broader context of human development in order to underscore the relevance of an array of factors, well beyond the health sector, that impact on overall well-being and health.



## Study setting

This paper is based on field work conducted in the Wosera district, East Sepik Province of Papua New Guinea from late 2005 to early 2006. The Wosera district is part of the Abelam linguistic group and is one of the least developed areas of Papua New Guinea. Malaria is endemic and is the second leading cause of medical admissions and the third leading cause of death (Genton et al., 1995). In 2004 antenatal coverage in the Wosera was recorded at only 48%, (National Department of Health, 2005), below the national average of 58% recorded in 2006 (WHO/WPRO, 2008). Of the rural citizen population in the East Sepik in 2000 only 42.7% of women were literate, lower than the national rate of 46.3% (National Statistics Office, 2002, p.38).

The participants in this study lived within one hour's walking distance from a sub-health centre run in association with the local Catholic mission. It was staffed by five to seven people, consisting of a minimum two nurses and several community health workers trained in basic clinical and antenatal care, and with overall management provided by a Health Extension Officer (HEO). It offered primary health services at their outpatient department, a 12 bed inpatient ward and delivery room.

## Methods

A qualitative approach was used for data collection and analysis and included in-depth interviews, ranking exercises, focus group discussions (FGD) and photo narratives, a methodology similar to a FGD but instead photos were used of women at different stages of their lives (child, adolescent, adult) to guide the discussion. To understand the diverse health needs of women and the key determinants of health across the lifespan, 33 young women (18 to 24 years), 27 adult women (25 to 44 years) and 10 older women (over 44 years) participated in the study. Single and married participants, unmarried mothers, school attendees and young women out of school were actively approached and made aware of the study. Discussions were held at times relevant to the different needs and responsibilities of participants.

A focus group was held with six young men and eight adult men respectively. Male and female participants were recruited using snowball, purposive and opportunistic techniques. Ten community members were purposively sampled for their diverse experience of women's health issues. The sampling method used in the study was most acceptable for obtaining information to understand the local context, it was unobtrusive, allowed for the examination of emerging themes and it took account of the limited time frame.

The research was conducted with a total of 94 respondents who provided informed verbal consent. Discussions were held in *tok pisin*, the local lingua franca, by the lead researcher and research assistant and translation was provided by the research assistant if participants preferred to speak their local language (a dialect of the *Ndu* family of languages). Questions focused on what being healthy meant to participants and what was necessary for them achieve good health. The barriers to health and the options available to women to overcome poor health were also explored.

Interviews lasted a maximum of 1 h, with group discussions taking somewhat longer, continuing for up to 2 h in most cases. In-depth interviews and focus group discussions were recorded and transcribed. Data analysis initially involved the reading of field notes and the discussion of key findings. Codes were applied to segments of transcribed data to identify emerging themes, unanticipated findings and areas where further questioning was required. The software programme Atlas-ti was used to manage the data analysis process. Ethical approval was obtained in accordance with the requirements of the university's Human Ethics Committee and the Papua New Guinea Medical Research Advisory Committee. To ensure anonymity, pseudonyms are used throughout this paper.

## Findings

The themes that emerged from the research depict narratives of multiple health needs and show an unequal burden of women's domestic and productive roles, responsibilities and obligations. Three main themes emerged in the analysis of women's discussions of their health and its place within the social, cultural and economic context of their lives: 1) violence 2) heavy workload burden and lack of economic opportunities 3) limited use of health services. It is not the intention of this paper to catalogue all the ways in which these issues impact on women's health. Rather, the point is to reaffirm that in any given place and time, women's health cannot be understood in a way that is detached and separated from these kinds of social forces (Freedman, 1999b).

### *Barriers to women's right to health in PNG*

#### *Violence*

Violence affected women's lives throughout the lifecycle. Women experienced violence at the hands of their parents, brothers, sons, and by their husbands and in-laws in marriage. As described elsewhere in Papua New Guinea (Macintyre, n.d; Wardlow, 2006), women experienced a high degree of surveillance, chastisement and social exclusion if the boundaries of custom and convention were breached. The main reasons young women gave for being beaten by their parents or male siblings was that they had been caught socialising with an un-related young man in private, which was an unacceptable modern practice, as was wearing revealing clothes, drinking alcohol, smoking marijuana or going to a "six to six" disco party.

A premarital pregnancy took the familial abuse of a young woman to another level and could range from sustained verbal and emotional abuse to physical violence, particularly in cases where no marriage ensued. Consistent violent treatment could result in a young woman leaving the parental home to stay, if possible, with supportive relatives. Ideally a young woman's return to the family unit would be negotiated, because in Alana's experience, the alternative had serious social, economic and health consequences.

When I was older, after I had started menstruation, I did what I wanted, if I wanted to go to a dance I would, whatever I wanted to do I would. Being able to go to a dance is important. I would come back to the house and

my father would get a stick, spear, whatever and chase me. This continued on and on and he made me so wild that I left and moved from house to house until I ended up how I am, pregnant. So life is really hard now.

Male control over women emerged as a strong theme in discussions of intimate partner violence. Some adult women felt devalued by their husbands. Payment of brideprice entailed 'ownership' of a woman by her husband (Amnesty International, 2006; Eves, n.d.; WHO, 2005), and she was seen as "samting nating," (unimportant, meaningless) other than to fulfil her responsibilities and obligations in marriage. The impact of this treatment on women's self-esteem did not go unnoticed by Sally who explained:

Sometimes men want to be the head, they want to be the boss and put women down. When I want to look after myself and dress well, my husband is jealous for no reason. He does that to me and puts me and my ideas down so that I will become a "rubbish" woman. That is what men do.

As described elsewhere, the concerns and anxieties that arose from infidelity, polygamy and promiscuity were fuelling violence within communities (Haley, 2008; Haley & Muggah, 2006). Male suspicion of infidelity and jealousy meant a woman's movements were restricted, as if she was "long kalabus" (in jail), her appearance was scrutinised and as a community police officer identified, the end result could be a man verbally and physically assaulting his wife.

I see this happening a lot. Men hit their wives for this reason. They hit them because they are jealous, for no reason, about other men. A lot of men do it, especially young men. Young married men.

Men however claimed it was customary practice and their right to engage in multiple unions. Their descriptions of polygamous relationships however were quite different from the traditional pattern of polygamous marriage practiced by men who had significant resources and had gained status and prominence in middle life. For the men in this study polygamy was about sexual prowess and male control. Women were blamed for their husbands' infidelity and for a man taking a second wife because, as a young man mentioned, it was because she was "not looking after her husband properly (not fulfilling domestic obligations), not following her husband's wishes, or she was unable to bear children. Polygamy was seen by women to have inequitable outcomes due to men not meeting their obligations and fairly distributing their time, labour and financial and material resources among their wives and children. The following quotation from a nurse acknowledges the relationship between violence, polygamy and poor health.

In terms of women's health, what I have seen over the past months is that for some women, some of them don't live well because their husbands have married another woman and this causes violence within the family.

Esther stated that "these men from here, they are the bosses. We are their slaves." She recognised that men had greater freedom than women and expected their wives to

meet their demands without question. Rather than working in partnership with a man who took the lead to provide for his family, women were expected to "come underneath" men. Women recognised that not all men abused their wives and some couples did of course achieve a marriage where they worked side by side and cooperated on joint endeavours. Participants claimed that a man who assisted his wife to meet the demands of her daily workload and shared his earnings was also perceived to be the type of man who would never mistreat or "hit his wife."

Men and women agreed that men perform less labour relative to women and women received variable support from their husbands with subsistence activities. Although Adam recognised he was failing in his domestic obligations, as the following discussion shows, there could be serious social consequences if a woman questioned her position. A woman could expect a "panel beating," a colloquialism for physical violence, if she complained about her multiple responsibilities or her husband's inadequacies.

Adam: When a man doesn't follow his wife to the garden there will be problems. When it's late afternoon and she returns from the garden and you ask your wife for food she will ask "did you follow me? Did you help me with my work today?" This is where the problems arise, a lot of marriages break up over these issues. So at least we must work together with our wives.

Tony: If she doesn't cook our food then she will get a panel beating.

Andrew: That's where the problems start.

The physical and mental health implications of violence against women in the Wosera were significant. Women were beaten, verbally abused and locked out of their houses. Young and adult women recalled violent encounters that involved the destruction of their property, such as pots, plates and the ripping and burning of their clothes. If a woman refused to have sex with her husband, her "disobedience" could be physically and verbally admonished. A suspected infidelity or a woman not meeting her marital obligations were excuses used by men to rationalise the violence in public. A woman who was unable to become pregnant was also the object of her husband's anger since "marriage is to have children."

Several women in this study feared for their lives. Remaining in a violent relationship could result in serious injury as Angela and Beryl, two young married women discussed, or possible death, either at the hand of their husband (Kate) or by suicide (Beryl):

Kate: It was at a level that he would kill me. So that wasn't good so I slowly began to leave him. If I stayed with him and over time he became angrier and angrier, he could have killed me.

Beryl: We run away and go and stay with our parents or we go to court. Sometimes we think about hanging ourselves. He beats me often, so I get these kinds of thoughts. I will hang myself and end my life.

Respondents identified that leaving a violent husband was not without its difficulties. The power imbalance and the socio-cultural and economic consequences of leaving a

relationship that was perceived as risky could be far worse than the health risks of staying in the relationship. A woman's decision to leave was often dependent on whether her natal kin would provide her with social and economic assistance. Patrilineal structures also determined that a child was a member of their father's clan, with associated land rights and obligations. Esther took this into account when discussing her desire to leave an abusive polygamous relationship, in which she was the second wife.

I think a lot about leaving my husband, but then I think about my son. Because of our custom, I have a lot of brothers and if I take my son with me, there might be a problem in the future, there will be a lot of males and my son won't have a good quality of life. That's what I think about. I will stay with my husband until my son is 5 years old, then I will leave him with his father.

The findings documented here are consistent with the most thorough study of intimate partner violence conducted in Papua New Guinea by the Law Reform Commission, which showed that the two most common triggers of domestic disputes were sexual jealousy and a wife's inability to meet marital obligations such as cooking, cleaning and child-care (Toft, 1986). The women in this study were victims of male control, jealousy and promiscuity. Women lived in relationships characterised by physical and emotional abuse. These findings illustrate the struggle of women to keep themselves healthy when confronted with a harsh reality and the abuse of their rights in their daily lives.

#### *Workload burden and lack of economic opportunities*

Women repeatedly stated that their workload was a major constraint to their health. The multiple responsibilities of a woman's workload involved the production of food crops, such as sweet potato, taro, corn and sago, firewood and water collection, the provision and cooking of food for domestic consumption and all laundry and child-care activities. A woman's workload burden extended to the constant struggle to find money for household items, clothing and children's school fees.

A man's lack of support and assistance to his wife to meet the demands of daily life were a constant cause of marital disputes. Women were aware of the inequities within the marital relationship and the unachievable expectations that their husbands placed on them to meet a heavy workload without assistance. An excuse regularly given by men was that a woman's workload was "*wok blong ol meri*," (women's work), and woman's role in marriage was to work hard and bear children and "not to relax."

In the two decades since the Law Reform Commission study, this research suggests that the changing attitude of women regarding social and domestic obligations noted among urban women is becoming apparent in rural areas. As Toft (1986, p.15) found, urban women "have reassessed their role and rejected their previous subordinate position." The women in this study regularly expressed concern about their position and were less prepared to accept their subservient status. Carly questioned for example, "why have I married this kind of man? One child will cry, another one I will put in the sling, another on my shoulders. It's really hard."

It is also possible that the less submissive stance of women was causing younger men to react by asserting their authority in the marital relationship through violence.

The burden of a heavy workload was exacerbated by having to provide for a large family. Twelve of the 33 young adult women had one or more child. Adult women had an average of 3.9 children, increasing to an average of 5.9 for older women. It is not surprising that women complained about the physical and economic strain of having many children, since they were ultimately responsible for meeting all domestic needs. Research has shown that children from large families are also likely to be undernourished, undereducated and poor (Defo, 1997).

Women of all age groups consistently described the stress, anxiety and worry they experienced about meeting the financial and physical demands of their daily lives. The circumstances of want created an oppressiveness in young women's lives (Polakoff & Gregory, 2002). Young women struggled to meet their basic needs on a severely restricted budget. Adult women faced persistent demands and expectations to provide for their family in circumstances that were often isolating and beyond their control. The emotional problems and worry that was described in adult women's accounts of their health was clearly emerging in young women's narratives, with young women exposed to factors, such as social and economic stress, that affected their confidence, sense of independence and self-esteem. All participants described the physical manifestations of their stress and anxiety, which included headaches, inability to sleep, dizziness and weakness. Married women also complained that exhaustion and chronic aches and pains in their legs, arms, shoulders and lower back were evidence of the heavy physical toll of their constant workload demands.

#### *Access to essential health services*

The women in this study faced a formal health care system that did little to meet the physical, emotional and mental health needs they identified and which gender-sensitive research highlights. A combination of government, churches and private organisations provide health services in PNG. Besides the formal health services, village health volunteers, traditional birth attendants and traditional healers also provide health services in some rural communities (United Nations, 2001). The 1974–78 National Health Plan committed the country to primary health care (PHC) (Connell, 1997) and established aid posts in rural areas, staffed with community health workers (CHWs) offering basic services – anti-malarial tablets, aspirins and treatments for cuts and sores.

At the time of this study, the majority of the aid posts in the Wosera had collapsed, either closed or were not staffed or supplied with medicine or equipment. There was no doctor available in the entire Wosera district and serious medical cases were referred to Maprik District Hospital, half an hour drive away, or to Wewak Provincial Hospital, at least 3 h drive from the Wosera. Women accessed treatment for what they perceived as "minor ailments" from health volunteers, trained as part of the Save the Children Fund, Women and Children's Health Project, or made the hour walk to the locally Catholic-run health centre.

As found in other developing country contexts (Kelaheer et al., 1998; Tannenbaum & Mayo, 2003), women faced a system focusing on a singular dimension of health rather than

addressing a woman as a whole person. Services for women focused on reproductive health services, namely Maternal and Child Health clinics. As documented elsewhere (WHO, 2003; Wong, Li, Burris & Xiang, 1995), these programmes prioritised infant and child survival to the neglect of women's health and they neither took account of the health needs of women who were not pregnant, nor accommodated women's changing needs throughout their life cycle. Although the two nurses interviewed for this study made a connection between poor living conditions, stress and women's ill-health, a lack of resources, limited staff training and time constraints restricted their capacity to respond to the psychosocial needs of their patients.

The constraints of gender and social, economic and cultural factors resulted in poor and often older women and girls being less likely to have access to appropriate care or to seek adequate treatment (WHO, 2003; Wyn & Solis, 2001). Despite their ailing physical status, older adult women rarely sought treatment from the formal healthcare system, preferring traditional cures or basic treatment offered by the health volunteers. Lack of mobility, limited financial resources and lack of social support were the main factors inhibiting older women's access to health services.

Young women's accounts showed they did not access health care in a safe or comfortable environment. In PNG it used to be law that only married women could receive contraception from government clinics and that both husband and wife had to sign a consent form. Although the law has changed, so that a woman no longer needs her husband's consent, young unmarried women were entirely excluded from accessing family planning, let alone basic relationship advice from the Catholic-run health centre or family planning and health volunteers. Premarital sex was seen as culturally, socially and morally inappropriate and as such young women were labelled as promiscuous and criticised for their family planning requests. The end result was a degrading and insensitive health care encounter for young women. This is consistent with the findings of other studies that show the delivery of health care as being affected by poor communication and information exchange and condescending attitudes of health workers which work to intimidate and shame (Kelaheer et al., 1998; Wathen & Harris, 2007).

Although there was a general appreciation expressed by participants about the availability of medicine, the health system was fragmented, involved long waiting times at poorly staffed and under resourced health centres and hospitals and put competing demands on women's time, as Carly's comment typifies:

Those of us who haven't washed the plates and go to the health centre, we think a lot about these things. We want to go quickly to the health centre, we have to wash the baby's nappies, wash the saucepans and plates. If I go in the afternoon then I will have to cook dinner in the late evening.

A consequence was that adult women delayed seeking medical care and suffered an illness in silence. Although they received little support in their domestic duties, women were expected to meet their responsibilities and not disrupt household organisation. Men were reluctant to allow women to participate in activities that would take them

away from the confines of the village or garden and as described elsewhere in PNG, if a woman was not obviously ill and attempted to seek treatment at a clinic alone she would likely be accused of other intentions (Macintyre, 2000). Together with existing barriers to health care such as lack of time, knowledge and financial restrictions, women learnt to prioritise the well-being of others over themselves. Beth's account shows that this could result in self-care neglect.

We go to the health centre if we are really unwell. But if we are only a little sick we think about work and we go and harvest taro or sago. If we go to the health centre who will be there to help our mothers to do this kind of work?

The health system itself was also responsible for the perpetuation of social inequalities against women. Women who sought treatment for violence-related injuries were made to feel somehow responsible for their perpetrator's actions. This did little to allay Tracy's fear of speaking out against her brother-in-law:

My husband's older brother hit me with a stick. I felt a lot of pain so I came to the health centre. And the nurses asked me "what did you do that made him hit you?" I said, "I don't want to talk about it because it will make him angry again and I'm afraid." I was thinking a lot about that. The nurses forced me to talk though. So I told them that my husband's older brother hit me on my hand and it became very swollen. I couldn't lift it. I was telling the nurse my story and then the nurse responded by saying, "what did you say to him that made him hit you?"

## Discussion

This paper has analysed the inequalities at the heart of women's health in Papua New Guinea and that impede the realisation of the right to health. Women's work and the physical burden of women's roles, marriage and threat of violence, and an unresponsive and inappropriate health service are major risk factors for women's health in developing countries (Meleis, 2005; Schoenfeld & Juarbe, 2005). This is consistent with the findings of this study which show that women's familial, productive roles and socioeconomic status intertwined to threaten their health. Women were situated in a social, cultural and economic environment that infringed on multiple rights, sustained unequal power relations and allowed for the perpetuation of violence against women.

Maternal death rates in Papua New Guinea are not declining despite a focus on maternal and child health by health workers, the national government and international aid agencies over a considerable period of time (Byford, 2005). The findings in this paper challenge the assumption that more hospitals and technological interventions will reduce maternal mortality. Women in PNG experience poor health because their health is not valued in itself and because women are discriminated against, abused, expected to meet unrealistic obligations, violated and denied access to appropriate and equitable services on a daily basis.

The findings show that the demands and restrictions that men imposed on girls and women and the threat of violence, if these were ignored or defied, were major factors limiting



women's choices and right to health. Similar to Goicolea's (2001) study of Ecuadorian women and their accounts of "machismo" and its relationship to gender violence, men took a number of actions to prevent their wives and daughters from having contact with those outside the domestic realm, which served to confine women to the narrow limits of their assigned gender role. As described elsewhere (Amnesty International, 2006; Macintyre, 2000; Moss, 2002; Schoenfeld & Juarbe, 2005), the expression of violence took a large toll on the psychological and physical health of the women in this study.

#### *Addressing women's right to health in PNG – using a rights-based approach*

The international literature is growing on the ways the gender divide compromises women's ability to access appropriate and equitable health care (Cohen, 1998; Meleis, 2005; Vlassoff & Bonilla, 1994). Instead of viewing health services for women through the lens of reproductive health, biomedical frameworks and the promotion of personal responsibility, a human rights framework would focus on the multiple roles of women and their experiences with fear, vulnerability, exploitation and oppression throughout the life cycle. Services sensitive to gender and human rights would see an improvement in provider knowledge of women's health problems and the socioeconomic factors determining patterns of health and illness, the sharing of information and joint decision-making (Khoury & Weisman, 2002). These would be positive first steps in the attempt to address women's vulnerability to inequitable care across the life span.

The level of violence against women in Papua New Guinea is a major obstacle to development and improvements are critical for progress towards the Millennium Development Goals (Meleis, 2005; WHO, 2005). As long as violence against women and the acceptance of violence more generally in PNG persists, programmes aimed at improving women's economic and social status will be ineffective. The Government of Papua New Guinea, international and national civil society organisations and donor agencies must explicitly recognise that violence against women and the social and economic discrimination of women is a serious violation of human rights and a pressing development issue (Bradley, 1994). A person's gender, marital or relationship status does not change their right to have his or her right to health respected, protected and fulfilled.

#### **The way forward**

The major reason women continue to die from pregnancy-related causes in Papua New Guinea is that they are continually discriminated against as women throughout the life span. The severe neglect of women's health is a violation of their human rights (Gruskin et al., 2008) and this violation must be investigated precisely to determine where the responsibility lies so that appropriate policy changes are introduced as a matter of priority (United Nations, 2006). Because the poor maternal mortality rates in PNG are socially produced, they can only be socially ameliorated, and as such, policies underpinned by the right to health must incorporate other crucial issues of women's health, not least the vital

importance of reducing violence and improving the psychosocial health of women. This means that health policies must be centred on human development – equitable, inclusive, non-discriminatory, participatory and evidenced-based – and which alleviate and are responsive to the social inequalities inherent in women's health, inclusive of maternal health. The principles and standards derived from international human rights treaties (both those specifically referring to women and gender, and those directed to civil, political, social, economic and cultural rights generally) should guide policy formulation and intersectoral programming in women's health, in all phases of the programming process (United Nations, 2006).

The poor health statistics and inequalities facing women in PNG must be used as a platform with which to galvanise the Government of Papua New Guinea to develop a legislative framework that takes into account the different and inequitable needs of women and men in allocating resources for health promotion, prevention and care. The issue is one of reducing inequalities in health, not only in access to health care and the authors suggest that a rights-based framework provides the necessary social and political leverage to advance the health equity agenda as promoted in human rights and legal frameworks. The integration of human rights and health might not be high on the agenda of Papua New Guinea and its major donors but as Gruskin, Mills & Tarantola (2007) emphasise, public-health efforts that consider human rights are likely to be more effective than those that neglect or violate rights. Papua New Guinea will not achieve sustained progress or achieve its commitment to the Millennium Development Goals without recognising human rights principles as core principles of health policy and health care delivery in the country.

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## **Appendix III**

**Copy of non-published version of article: *“I worry so much I think it will kill me”*: Psychosocial health and the links to the conditions of women’s lives in Papua New Guinea**

Hinton, R., and Earnest, J. (in press, 2010). "I worry so much I think it will kill me": Psychosocial health and the links to the conditions of women's lives in Papua New Guinea. *Health Sociology Review*, 19(1).

### **Abstract**

*The links between the social and material conditions of women's lives in Papua New Guinea and their poor physical and psychosocial health has had limited examination. This article describes a qualitative interpretative study that examined the ways in which women expressed the links between their psychosocial health and the social, cultural and economic environment in which they lived. In-depth interviews, focus group discussions, ranking exercises and photo narratives were used to explore women's experiences of health throughout their lifespan.*

*The innovative use of these qualitative tools and participatory methods provides new insights to challenge the discourse of health provision in Papua New Guinea. The findings document women's experience and lives in a challenging environment that leads to "worrying" and "thinking too much" and which imparts and exerts a powerful influence on health. Women's accounts illustrated feelings of powerlessness, helplessness and hopelessness when faced with financial constraints, unsupportive social relationships, violence and heavy household workloads. The article proposes the need for a thorough examination of women's psychosocial health concerns to situate women's health programmes and interventions within the context of their lives.*

### **Keywords**

health policy, psychosocial, qualitative research, sociology, stress, women's health

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There has been limited examination of the links between the social and material conditions of women's lives in Papua New Guinea (PNG) and their poor physical and psychosocial health. Macintyre (n.d) recognises the health status of women reflects the complex ways that oppressive patriarchal values maintain patterns of inequality and disadvantage based on sex. The growing dialogue and debate around HIV transmission dynamics in PNG has raised awareness about the impact of social conditions on health. Sexual health and female risk-taking behaviours are strongly affected by women's social, cultural and economic situation, and specifically gender norms and relationships (Hammar 2008; Wardlow 2002, 2006).

Women's psychosocial health problems and forms of distress, such as anxiety and stress, are beginning to receive closer examination in the international literature for their links to the social and material circumstances of women's lives. Mental health problems are examined not only as clinical outcomes of psychiatric conditions, but as social, economic and cultural in origin and in their influences on physical health (Avotri and Walters 1999). The persistent demands and expectations placed on women to provide for their family in circumstances that are often isolating and beyond their control, resulting in what Doyal (1995) terms "idioms of distress". Psychosocial health problems, such as anxiety, fatigue and depression, reflect the powerlessness and challenges women encounter.

### **Psychosocial health problems of women in the developing world**

The determinants of psychosocial health are gaining attention in discussion, dialogue and debate of women's health in the developing world (Avotri and Walters 1999; Schoenfeld and Juarbe 2005). Poverty confronts women with a multitude of psychosocial stressors and material challenges linked to social status, social isolation and control over life circumstances (Hinton and Earnest in press). Financial insecurity, gendered roles and heavy workloads have been shown to impinge on Ghanaian women's physical and psychological health (Avotri and Walters 1999). In a recent study with comparatively educated and affluent Emirati women, women's multiple roles, early marriage, frequent childbearing and polygamy were consistently linked to increased fatigue and anxieties (Winslow and Honein 2007). Women's accounts of their health illustrated feelings of hopelessness and helplessness when faced with overwhelming life circumstances. Women identified physical ailments which were related to the conditions of their lives and that they accepted as a normal, learning to believe suffering is their lot (Winslow and Honein 2007). This reflects the psychological pressures, the inability to voice their distress and the complexity of the social, cultural and historical context of women's health experiences (Hou *et al* 2005; Schulz and



Lempert 2004). Walters (1993) has shown stress, anxiety and depression are experienced differently by women depending on their age, family structures, socioeconomic status, ethnicity, culture and occupation, as well as their clinical status. These variations between women bring much needed attention to the social production and social origin of mental health problems.

### ***Psychosocial health and women in Papua New Guinea***

Poor social and economic circumstances affect women's health throughout the lifespan. Studies reveal women in Papua New Guinea experience high levels of violence (Amnesty International 2006; Lewis *et al* 2008; Toft 1986). According to the government of PNG:

*Young women all over the country are at high risk of rape, gang rape and other forms of violent sexual assault, and the attendant fear accompanies them in many aspects of their daily life in urban and rural settings* (Committee on the Rights of the Child 2003:45).

Intimate partner violence has reached unacceptable levels in Papua New Guinea (Amnesty International 2006) and regional surveys have revealed that 67% of rural women have been hit by their husbands (Bradley 1994; Toft 1986). The practice of bride price and polygamy is prevalent, reinforcing widespread expectations of patriarchal dominance and male control over women (AusAID 2008). These practices are significant determinants of HIV transmission among women and only further entrench women's economic marginalization and dependence on men (Lewis *et al* 2008).

The risk of violence, combined with the physical and psychosocial burden of women's roles are major risk factors in women's health in Papua New Guinea. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over life circumstances have powerful effects on health (Leipert and Reutter 2005; Wilkinson and Marmot 2003). Gender differences, that result in low status, powerlessness and oppression, have been cited as the basis of female suicide in Papua New Guinea (Booth 1999; Counts 1980) and elsewhere, including South Asia (Niaz 2003; Girdhar *et al* 2003) and Afghanistan (Rawi 2004). However, health policy and women's health programmes remain aligned with safe motherhood, with the overall goal to:

*Prevent illness, suffering and deaths among women in PNG through gynaecological, pre- and post-natal care and supervised deliveries* (National Department of Health 2000:48).

There is a lack of available data on the incidence of mental health disorders in Papua New Guinea and the physical and psychosocial impacts of women's experiences on their health remain unexplored. Over 18 years ago Gillet (1990) called for an immediate investigation into the impact of mental health disorders in women in PNG, followed by a comprehensive plan of action. To date, this investigation has not occurred and a plan of action has not been developed. Women in Papua New Guinea continue to be deprived of necessary treatment and care.

Literature in PNG is limited in what it can tell us about the health-related experiences as perceived by women themselves. The objective of this study was to prioritise women's accounts and definitions of their own health-related experiences, as shared and narrated by the women themselves, and to examine health as it is situated within the socio-cultural context of women's lives using a qualitative interpretative approach. We explored women's health care needs across different age cohorts to understand the ways in which women were affected by the multiple circumstances of their lives. Emphasis was placed on the participants' perceptions and interpretations and by using qualitative techniques we were able to explore the complexities and meanings of their experiences and views in a more natural and informal setting (Liamputtong and Ezzy 2005). It also allowed for the identification of inadequacies in care and a better understanding of whether the health priorities of women were being addressed.

## **Method**

### ***Study site***

The study was conducted in the Wosera district, East Sepik Province of Papua New Guinea from mid 2005 to early 2006. One of the least developed areas of Papua New Guinea, the Wosera is part of the Abelam ethnolinguistic group and is located between the Prince Alexander Ranges and the Sepik River. There is a heavy reliance on subsistence production for household consumption, limited cash earning opportunities and low per capita incomes in the district (Curry 2005).

Abelam clans are patrilineal kin groups and every man and woman belongs to the clan in which he or she was born (Huber-Greub 1990). Within a village several clans are represented. A woman is a metaphorical “flying fox”, that is, unlike a man or “coconut palm” she is not bound to a socially defined point or attached to land with roots. The complementary gender roles and responsibilities in Abelam society have somewhat altered since earlier ethnographic descriptions (Huber-Greub 1990; Kaberry 1941; Scaglione 1986). Women conduct most of the daily subsistence, domestic duties and have had to take on some previously male tasks (such as cutting down the sago palm), with men becoming more involved in cash-earning and social activities which often take them out of the village. Of the rural population in the East Sepik, in 2000 only 43% of women were literate, lower than the national rate of 46% (National Statistics Office 2002).

Recent women’s maternal mortality statistics reveal Papua New Guinea as having the highest in the Pacific region (870/100,000) (World Health Organization [WHO]/Western Pacific Regional Office [WPRO] 2008). In 2004 antenatal coverage in the Wosera was recorded at only 48% (Papua New Guinea National Department of Health 2005), below the national average of 58% (WHO/WPRO 2008). Only 12% of births in the Wosera had a skilled attendant at delivery (National Department of Health 2005).

#### ***Participant recruitment procedures***

Participants were selected using opportunistic, purposive and snowball sampling methods (Patton 2003). Concerns for representation were met with an in-depth analysis of the evolving information for its common or irregular themes. Date of birth was agreed with participants as a valid form of categorisation. When age was unknown, other social and cultural variables were used to differentiate women including peer group relationships, workload, marital status and number of children. Because self identification and social acceptance came to underpin the sample process, several young women under the age of 18 years participated in the research and two women who were over 44 years identified with the adult women age group. Young and adult men were also selected to participate in the study to consider their perspectives of the main determinants of women’s worries and concerns and to examine how they saw themselves in relation to women’s health.

The first author (RH) has worked in the Wosera district for several years and is fluent in *tok pisin* (Melanesian pidgin, the lingua franca of Papua New Guinea). She is very familiar with the study site and prior to conducting the research a community meeting was facilitated by the first author and local research assistant. Information was provided in *tok pisin* about the project, including the aims and objectives, the significance of the research and the proposed methodology. Consent for the project was given collectively by village leaders and community members and together with the sampling techniques, this ensured a culturally appropriate and non-invasive approach to the recruitment process.

#### ***Methods of data collection***

Rapid ethnographic assessment, a modification of traditional ethnography, accommodated a combination of qualitative methods and a shortened time line. Qualitative methods made it possible to capture women’s own perspectives and definitions of health within the context in which health was experienced (Wadsworth 2000). The study was inductive in its approach, moving from observations and open questions to more general conclusions. Within-methods triangulation and cross-validation of the data reduced the possibility of bias and contributed to the depth and rigour of the data (Denzin and Lincoln 2008; Hesse-Biber and Leavy 2006). In addition, multiple methods were used so as to not discriminate against illiterate and vulnerable participants, an important consideration in the social context and the high illiteracy rate (Kitzinger 1995).

#### ***Focus group discussions***

We conducted four focus group discussions with two groups of young and adult women respectively. Each discussion lasted for up to two hours. Focus group discussions enable discussions with a relatively small number of people, from a similar socio-cultural background. They allowed for the exploration of women’s knowledge and experiences and provided a rich and detailed set of data about perceptions, thoughts, feelings and impressions of women in their own words. A focus group discussion was also held with six young men and eight adult men. It was

important to gauge men's views of women's health since women identified their relationships with men as central to health.

#### *Photo narratives*

Four photo narratives exercises were also conducted with two groups of young and adult women. Photo narratives were similar to a focus group discussion but photos of women at different stages of their lives (child, adolescent, adult) were used to guide the discussion. By showing a culturally relevant image, such as a young girl selling goods at the market, an adult woman washing plates, structure was added to group discussions without compromising flexibility (Ulin *et al* 2002). Photos stimulated participants' interest and imagination and they were able to organise and articulate their thoughts with a clear point of reference.

#### *Participatory diagramming*

Four participatory diagramming exercises were conducted with the same combination of focus group discussion or photo narrative participants. These exercises consisted of the identification and prioritization of health problems with participants using local materials to symbolise health problems (such as a stick was used to represent violence against women since weapons were often used against women). Pebbles were used to rank and indicate relative importance (five pebbles high priority, one pebble low priority). Similar to focus group discussions, the interaction between group members was critical and participants worked together to produce data which was visual and diagrammatic as much as verbal or textual (Kesby 2000).

#### *In-depth interviews*

A total of 30 in-depth interviews were held with young, adult and older women. Many of the in-depth participants were known to the first author, having been a participant in either a focus group discussion or a participatory diagram. This enabled feedback to be given on some of the preliminary findings and we were able to continue to engage women in the research process. On average, each interview lasted one hour. The first author who has lived and worked in Papua New Guinea for several years led interviews in *tok pisin* with the assistance of a local research assistant and a local field assistant, who also acted as cultural interpreters. The research assistant facilitated discussions with older participants who preferred to speak their local language (a dialect of the family of *Ndu* languages).

#### *Key informant interviews*

Eleven community members were purposively sampled for their specific knowledge and diverse experience of women's health issues. Key informants included two primary school teachers, two high school teachers, two village health volunteers, a village court magistrate, community police officer, pastor and two nursing officers. On average interviews lasted one hour.

#### **Ethical considerations**

Ethical approval was obtained in accordance with the requirements of the Human Research Ethics Committee at Curtin University and the Papua New Guinea Medical Research Advisory Committee. To ensure anonymity, the real names of participants have been replaced with pseudonyms throughout this article. Participants were informed of the purpose of the study prior to discussions taking place. They were assured of confidentiality and informed they could withdraw from the study at any time.

#### **Data analysis**

Data analysis was conducted concurrently with data collection. It involved initially reading, rereading, discussing the data. This helped to immediately identify emerging themes, unanticipated findings and gaps in the data. Waiting too long to read and reflect on the data would have hindered the revision and refinement of the research questions, terminology and methodologies.

We applied a "label" to segments of transcribed data for the identification of general ideas and themes. The common data for each code was analysed separately, which gave rise to new sub-themes and a more detailed analysis of the data. By identifying how commonly themes occurred in the data it also became clear whether certain themes tended to emerge in specific age groups or more generally across groups. The software programme Atlas-ti version 4.1 (Muhr 1997) was used to manage the data analysis process.

## Findings

Thirty three young women (18 to 24 years), 27 adult women (25 to 44 years) and 10 older women (older than 44 years) participated in the research. Young women had an average education level of Grade six, compared with an average of Grade four for adult participants and Grade one for older participants. One third (n=11) of young adult women were married and nine had one or more child. Three of the single young women had a child. The majority of adult women were married and had an average of four children. Half (n=5) of the older respondents were widowed.

Psychosocial health problems figured predominantly in women's accounts of their health. In exploring the causes of poor health women drew on an idiomatic repertoire which was distinctive to all participants. The idioms of distress among the women in this study found expression in "*wari*" (worry), and "*tingting planti*" (thinking too much) and their associated symptoms. The idioms were used interchangeably by all women across the life span and capture what Doyal (1995) describes as the complex physical and psychological responses to the contradictory and demanding challenges associated with the social conditions of women's lives. The financial constraints, unsupportive social relationships, violence and heavy workload demands women describe below were viewed through multiple lenses of gender inequity, social and cultural disparity and subtle forms of resistance (Hinton and Earnest in press).

In presenting women's voices and forms of distress we grappled with nuances and lenses of appropriate representation (Liamputtong 2007; Sangtin writers and Nagar 2006) and the participant's shared meanings of worry, anxiety, unpredictability and resilience. Although "worrying" and "thinking too much" are standard expressions in response to social problems in Papua New Guinea, the analysis also revealed and documented that these expressions represented not only the anxiety and tension in the daily lives of women but also highlighted the unique strengths and resilience. Similarly women described many of their problems as a "*hev*" irrespective of the type of problem experienced or causal factors. The expressions did not always capture women's feelings of anger and unhappiness, the severity of women's problems or the extent of their vulnerability and the underlying tensions of resistance. However, we have used the idioms of "worrying" and "thinking too much" in this article as these expressions were used consistently by the women in the study and were interwoven within the shared stories of their lives.

### ***"I think a lot about where I will get money": Concern associated with resource constraints***

Young women's narratives about their attempts to find different pathways to access money and to meet basic needs highlighted a mixture of frustration, anger and feeling "*nogut*" (bad). Lack of money was identified in the two participatory diagrams conducted by young women as their main health concern and the most frequent cause of worry. Represented in both groups by a PGK 1.00 coin (AU\$ 0.45cents) the following narrative of single young women presents their reasoning:

*Beth: We need it for school fees, to buy good things, to pay for bride price, funeral costs, to pay compensation.*

*Rose: We need money for clothes, to buy string to make bilums (string bag), we need it.*

*Annalise: If we don't have money we can't go to the market and we just stay at home. That makes us feel worried.*

Nita described how she would repeatedly think about the issue:

*If I don't have money then I will feel worried, like, I will think a lot. Where will I be able to get money from to buy what I need? This is what I think a lot about.*

Single and married young women described the helplessness and hopelessness they felt about their situation and their inability to change their circumstances. This stemmed from the severely imbalanced state of gender relations that existed between men and women (Hammar 2008). Single young women felt helpless to alter their position which kept them at the mercy of their parents. On the one hand they were a target of constant workload demands while, on the other hand, they were dependent on their parents for social and financial support. It has been suggested that when young people's control over a situation is perceived negatively, worry can ensue (Barahmand 2008). Likewise when the young women in this study struggled to think

through or cope with their frustration and lack of control over life circumstances, they expressed a vulnerability to worry:

*Sometimes living with my parents is good. If I work hard then they won't get angry with me. Then I will be ok. When they both get angry with me, then yes, I have many different thoughts. Like I feel I want to run away and go and stay somewhere else. I get these kinds of thoughts and I don't want to live in this house anymore. If they get angry with me, then that is how I feel.*

The high costs of education were major source of anxiety for young women. Several participants had been being withdrawn from school by their parents due to a lack of financial resources. One young woman recalled a male sibling's education being prioritised over her own. Just under half of the young women who participated in this study achieved an education higher than Grade six, and only five were currently enrolled in an education course. Access to a high school education (Grade 10 to 12) represented freedom from parental pressure and was perceived by young women to increase their potential for future social and employment opportunities.

Despite parental restrictions and the perception they had unfair and high expectations placed on them, the death of a parent, in particular the death of a father, was identified by young women as a major health issue and a source of profound worry. Because single women derived their status from their father, in one young woman's opinion, it was a father's responsibility as "head of the household" to ensure the economic and material stability of the family. This was despite direct experience to the contrary and her dependence on her mother and siblings for financial support:

*For children who have a father, their father will buy them what they need. For children who don't have a father, they will sit down and worry. With the death of their father they will worry, they don't have enough clothes to wear. They see others wearing good clothes and they will think if their father was alive they would also have good clothes.*

Sylvia, a young woman who had a premarital pregnancy, was constantly the target of her parents' abuse and threats. Abandoned by her boyfriend and outside a formalised relationship such as marriage, she was forced to compensate for her "misdemeanour" by undertaking the majority of workload and household tasks in her family. As a single mother Sylvia faced an uncertain future. Despite her difficult circumstances, she feared her situation would be much worse with the death of her parents:

*My well-being, it depends on if I find a husband. How will I live? Will I stay in this situation until my child is grown up? Will I live happily or not? If I stay with my parents and they die what will happen then? I don't know. How will my life be?*

Many of the young married women described their attempts to manage the new roles and responsibilities that came with marriage. For Beryl this involved considerable psychological strain:

*I have a husband. He doesn't follow me [to the garden] so I have negative thoughts and my thinking gets confused. I don't have any way to overcome this problem. I have thought so much about it that now my thoughts get really mixed up.*

A difficult marital situation worsened for a woman with the death of her parents. Doreen had to manage the burden of her heavy workload and domestic demands without access to a broader support network other young married women could still depend on:

*The girls my age, their parents are still alive and their parents can help them with their work. They go and help them and if they need anything their parents can always give it to them. Their brothers too, they go and help their sisters. For me, I don't have this support. This is my biggest worry. It is what I think most about. Every day, if I find it hard to do some heavy work, my thoughts immediately go back to my parents again.*

***"I worry a lot about my life with my husband and sometimes it makes me want to cry":  
Worrying about unsupportive marital relationships***

The descriptions of adult women show they were living in circumstances where life was a constant struggle with psychological strains and worry associated with financial constraints, a heavy

workload and, in most cases, an uncooperative and unsupportive husband. Contributing to their concerns was a sense of uncertainty about the future and their ability to provide for their children's social, material and economic needs. During a participatory diagramming exercise adult women identified worry and thinking too much as an important health concern, represented by a ripped skirt. This symbolised the worry women felt to the point where they no longer took pride or care in their appearance. The following narrative from the exercise is indicative of most discussions of women's main health concerns:

*Carol: Who will help me?*

*Pamela: A husband doesn't always support his family. He gives his money to another woman and not his wife and his wife will be sick with worry.*

*Irene: A husband must be with his wife. Who will help me with the sago? I worry and think a lot about this. If you are able to cut the sago palm then you will have to do it. If not, you will have to find it at the market. He needs to cut the big bush.*

*Vicki: Some women don't have a good life with their husbands. They don't have enough food, or money, no money for their children's school fees.*

Several adult women who had been neglected or abandoned by their husbands and were solely responsible for their family's sustenance were particularly vulnerable:

*I feel really worried because I get no support from my [former] husband. He doesn't try to help me with any money for our son. It is solely for this reason that I try to find ways to raise an income. I need to find money for my son's school fees.*

All married women reflected on the difficulties they had negotiating the marital relationship and their worry associated with the lack of assistance they received from their husband in all household and domestic duties. Many women were dismissive of their husbands. They resented the ways men expected women to be responsible for production and social reproduction, and to be a "good" wife, mother and in-law with limited social and economic support. Similar to Ghanaian women's accounts of their work and health (Avotri and Walters 1999), women were expected to provide for their family in circumstances which were becoming more difficult and that afforded them little control. The marital relationship was a constant source of worry, and women saw their husbands as the source of their problems. Male control over women emerged as a strong theme in discussions of intimate partner violence. Men stopped women from going out by themselves, inflicted violence against their wives and were suspicious of women's activities outside the domestic sphere. Violence had a significant impact on the psychological and physical health of the women in this study:

*Now when I go back to the house he will ask where I have been. He will ask what I have been doing and tell me that I need to feed him and the family before I leave the house in the morning. Then he will hit me. He will get his knife and come towards me. And I will tell him he can do what he wants. You want to hit me, that's up to you. You can do whatever way you want to. You want to cut me? He is a really angry man.*

Macintyre (n.d) asserts that perhaps more than any other factor, the cultural acceptance of violence against women is indicative of the naturalization of male dominance and reveals a deeply entrenched subordination of women. Women's expressions of distress reinforced the normalization of male dominance and patterns of violence. Women's use of the terms "worry" and "thinking too much" in response to male violence and conveyed women's fears and anxieties but the idioms did not always sufficiently capture the severity of women's vulnerabilities or the extent of their oppression.

Discussions with adult and young men revealed their sense of entitlement and ownership of women. They sought to control their wives movements, work and sexuality. In the same way Macintyre described men's justification for male dominance over women, the men in this study claimed the payment of bride price in which a woman's fertility and labour were acquired from her father, entailed husbandly authority and conferred a man the right to punish his wife who was not performing her duties as he determined. Children too were supposed to be cared for by women on behalf of their husbands. Male participants did recognise however the impact an unsupportive husband had on his wife's health and well-being as the following interaction reveals:

*Peter: If a husband is doing nothing at home and his wife comes home after working all day in the garden and sees him she will get angry. Cooperation is a big thing, helping women with their work.*

*James: A lack of cooperation is the cause of marital problems.*

*Peter: If there is no cooperation between a husband and his wife, then a woman will face many problems. We men we need to work hard to raise an income. Then our wives will be happy. If she doesn't have clothes or money then she will worry.*

*Daniell: Every day my wife works in the garden so I have to make her happy by looking after the children while she works. If I don't do that and the children go to the garden with their mother and she has to look after them as well, then there will be problems. She won't be happy.*

An uncooperative marital relationship led women to seek support outside of the household unit. Women across all age groups were vulnerable in their dependence on men for access to land and property and for having to rely on the compliance of others for support. It was a prudent woman who avoided a dispute with her natal kin or in-laws. The alternative would only exacerbate the constraints and instability of her position and restrict her access to broad social, material and economic support. This was particularly important for widowed or less active older women who depended on their children for financial, material and psychological care.

Sub-standard housing created a similar dependency that was a cause of dissatisfaction and worry. As in many developing countries, a woman's access to housing was through men (Wells 2005) and beyond their control to change. Some respondents described the impact poor housing conditions had on an already heavy workload. Emily was deserted by her husband and was relying on support from her natal family for her housing. She was in a tenuous position, the object of abuse and threats, and she had limited resources in her own right to take action to improve her living conditions.

Although many women were highly critical of their marriages, several respondents were trying to cope with the death or desertion of their husband. The social ramifications were extensive, as Trudi explained:

*We think back to how her husband treated us all when he was alive. The death of a husband is a big problem. Its big, a lot of worry is caused by it.*

Despite complaining bitterly about the lack of support they received from their husbands, women reflected on the social security they experienced in marriage and in having a husband to represent the family in public. Being an adult woman alone was difficult and unmarried and widowed women spoke of being the target of gossip and shunned by married women. A woman without a husband was closely monitored as a potential threat by other women. An innocent glance, let alone a conversation with a married man, could spark an altercation, threats and at worse, a physical attack against a woman by the man's wife. This treatment provided an extra burden of anxiety and concern for widowed, single mothers or women deserted by their husbands.

***“Because I worry so much I have permanent pains in my body”: Physical expressions of distress***

The physical health problems women highlighted were discussed in terms of the worry and concern they felt about their inability to change the conditions of their lives. Women mentioned a variety of physical complaints caused by worry, including loss of appetite, tiredness and inability to relax or sleep. Constant worry and a build up of anger and frustration was associated with more serious physical illness such as dizziness, headaches, fever, and a head, which was heavy and solid “like a stone” and that prevented a woman thinking clearly. Thinking too much could make a woman vomit, and in some cases, result in severe stomach pain or cause her to faint – symptoms that were predominantly psychosomatic. Women's heavy and relentless workload burden was also directly associated with chronic physical aches and pains, physical exhaustion and general weakness. Some women also experienced severe violence-related trauma. During a photo narrative exercise Sandy reflected on the life of a woman who was sitting underneath her house with her husband and children in one of the photos. She said the woman looked unhappy and worried. When asked why she might be worried Sandy began to describe the physical injuries she had sustained in the past from her violent husband:

*I had just given birth and my husband kicked me in my side. The side of my body now is constantly painful. The problem is now I can't lift heavy things, such as sago, yams or a heavy bilum. I can no longer carry them because I find it too painful.*

It was common for respondents to suggest if a woman worried too much, the worry could cause serious illness, or in the extreme, cause a woman's death. Many women's narrative show "dying of worry" was a very real and inevitable consequence of repeatedly thinking about a problem. Kate, an adult respondent, reflected on the causal relationship of constant worry and serious physical complaints. She did not see worry as an illness per se but it was recognised as a major health problem:

*Sometimes I am worried, I think too much about things and the worry makes me sick. Like malaria, even though we look after our health, mosquitoes bite us and we get sick. But there is another side to illness, and that's worrying. If I worry too much, worry can make me sick too. So because of that I make sure I don't worry too much. If I am worried today, tomorrow my worry will have finished. If you worry too much, for many weeks, or five days, one week or two weeks, then sometimes you will become sick. If you worry too much it will kill you. Some days these thoughts come, worry comes, but the next day you need to have good thoughts again. You get up and just go to do the work yourself. You have to forget your worries.*

Worry associated with disharmony or disputes within a family could also lead to an acute physical disorder. Respondents suggested unresolved disputes between a man and his pregnant wife, or between a man and his wife's family, could result in serious complications during child birth, such as protracted labour, foetal distress and quite possibly infant or maternal mortality:

*If a woman has been worrying a lot and she is pregnant, the child will also be affected by this worry. If the mother is worried, the child will also have this worry. Sometimes we mothers, we face many complications during childbirth. And the child too won't be healthy once it is born. The child will be born with worry. And the child might not survive. Or sometimes the mother will die and the child will survive. We face many difficulties because of this.*

Suicide was discussed as a permanent solution to women's worries and distress. Suicide has been discussed as a mode of social resistance adopted by women of many cultures because their rights have been neglected, they face chronic partner abuse (Douki *et al* 2003) and lack an effective and more direct means of affecting the behaviour of others (Counts 1980). Niaz (2003) suggests women are often so suppressed that instead of fighting for their rights, suicide is seen as a way out of economic deprivation and chronic hardship.

Many women in this study discussed their strategies to cope with the material and social constraints in their daily lives. However, many of the changes women desired - a reduction in school fees, a more communicative and less violent husband, supportive in-laws, better access to family planning, improved land use and resource sustainability and a decrease in the cost of consumables - required improvements in the social, economic and cultural structures that governed women's lives and the renegotiation of social relationships. Many of these changes were beyond a woman's control. Women were positioned in a set of social relations they could not change by direct action. Constant forms of distress associated with these constraints and an inability to escape from persistent pressures led some women to consider suicide:

*Sandra: You will feel like you want to die. I will kill myself. Hang myself from a tree. Some women drink medicine and commit suicide.*

*Tracy: I get angry with my husband and then I experience many problems. My head will ache, when I see him I think, forget it, I will just go and get medicine and kill myself. I get these kinds of thoughts. It's because of my husband's bad attitude.*

## **Discussion**

There has been limited examination of the psychosocial health of Papua New Guinean women and the perceived links to the social and material circumstances of their lives. The results of this study suggest that women's health problems were related to the constant struggle of their daily circumstances, which included unequal social relationships, economic constraints, workload



demands and regular abuse and violence. Women's idioms of distress - "*wari*" and "*tingting planti*"- were a response to circumstances where life was a constant anxiety and a struggle with psychological strains. Women expressed their vulnerability to the conditions of their lives in a variety of ways and many women felt they had high levels of distress.

The emotional problems and worry seen in adult women's accounts of their health were already emerging in young women's narratives. Young women were exposed to factors, such as personal, financial and relationship stress, which affected their self-esteem, confidence and acceptance by their peers. Young women attempted to direct their life in ways that would improve their control over life chances. Consistent with the findings of Barahmand's (2008) study of adolescent worry, these life chances, such as to have the opportunity to complete their education or to meet their social, economic and material needs, were associated with feelings of well-being in young women.

International literature suggests women's accounts of their health highlight the social and cultural roots of their problems and reflect the powerlessness and contradictions women encounter (Avotri and Walters 1999; Hidebrandt and Kelber 2005). The women in this study were expected to meet inflexible social reproduction and production obligations despite the unsupportive and unpredictable nature of their personal lives. Literature, discourse and evidence suggests that although people are very aware of the material context of their worry and concerns they often have no power to shape their circumstances or to effect structural change (Avotri and Walters 1999; Hidebrandt and Kelber 2005; Pietilä and Rytönen 2008).

Although many women conveyed a sense of determination, strength and displayed resilience to cope with adversity, this study exposes the "weathering" of women (Shulz and Lempert 2004) as a serious problem. Women were physically and psychologically distressed by constant exposure to, and efforts to mitigate, life circumstances in which there were many overwhelming social, cultural and structural challenges, as well as limited access to resources. Scaglione and Norman's (2000) analysis of resistance and agency amongst the Abelam, shows in circumstances where resistance has little effect, people simply withdraw, achieving strength through avoidance. For some women this meant it was easier to be submissive, take on additional economic and social responsibilities and ignore the threat of a violent husband.

Women's accounts showed they lacked the confidence to feel things would work out well and they had limited opportunities to shape their own destiny. This study documents, at an extreme level, women who spoke about suicide as a resolution for their struggles were experiencing an alarming sense of powerlessness in their daily lives and were severely constrained in their ability to change their circumstances by direct action. Suicide therefore was seen as way for women to communicate in a medium that they knew could not be ignored (Counts 1980). A woman's suicide has been described in the Highland and coastal areas of Papua New Guinea (Ayers Counts and Counts, 2004; Counts 1980; Wardlow 2006) as a social and political act, an expression of power and agency by the powerless against adverse social relationships.

Violence is a serious form of discrimination against women in Papua New Guinea and women who experience violence are less able to realise a multitude of related rights, including the right to health, education, employment and decision-making. In many parts of Papua New Guinea, including the Wosera, economic deprivation due to lack of land and property rights, patterns of out-marriage and social isolation (Lewis *et al* 2008) make more women dependent on men for economic survival, reinforce expectations of male authority and increase women's exposure to male violence (AusAID 2008).

Evidence shows prolonged exposure to psychological and emotional demands have the potential to cause physical illness, in addition to mental illness (Marmot 2006; Pietilä and Rytönen 2008, Wells 2005). The women in this study discussed psycho-physiological disorders, such as body pain, headaches and dizziness as symptomatic responses to long-term violence, personal suppression and subjugation of their feelings, that is their anger, frustration, fear and unhappiness. This is what Hou and colleagues (2005) have documented as an accumulation of traumatic stress. Physical health in itself was given low priority and only discussed in terms of the burden of a heavy workload, the lack of support received from men in production and social reproduction, violence and financial and material constraints. The emotional, mental and physical toll of women's day to day challenges requires immediate scrutiny. The authors argue, however,

that it is not enough to acknowledge the powerlessness, helplessness and hopelessness of women's lives. Immediate steps must be developed and implemented to address the inherent inequities in women's health.

### **Conclusion**

The high maternal mortality rate and the violence and discrimination women experience in PNG are all pressing issues that have informed public debates. However, the social, cultural and economic determinants of these problems and the physical and psychological impact on women's health are not consistently scrutinised, or reflected in public and health policy. The government of PNG has not taken much needed action against violence, particularly violence against women, which remains tacitly accepted in communities.

In Papua New Guinea there is very little data available on the mental health and psychosocial well-being of the population. Mental health service coverage is low (Gillet 1990; Macintyre n.d) and limited to acute clinical care. The National Department of Health (2000) recognises community mental health care receives little attention. Staff training is lacking, the patient referral system is weak and public awareness and community involvement is minimal. This study reiterates Gillet's (1990) call over two decades ago for an immediate investigation into the impact of mental health disorders, particularly among women, and the development of a comprehensive and relevant plan of action. A review and update of existing policies and mental health guidelines such as the Public Health (Mental Disorders) Regulation also requires immediate attention for its relevance to the lives of women in Papua New Guinea.

Improvements in the health of women in Papua New Guinea will only be achieved with sustained political commitment to public policies and a multi-sectoral effort at the individual, community and organizational level. The authors support Lewis *et al's* (2008) call for a structural approach to empower women and to examine existing gender norms in the Papua New Guinean context. Material investment is required in programmes to address the links between the low status and material deprivation of women, violence and women's poor physical and psychosocial health.

A closer investigation of women's lives, psychosocial issues and workload burden is required to situate interventions to improve women's health within the context of their lives. A transformation of current policies and standards of women's health aligned with safe motherhood and reproductive health and an expansion of services in the area of psychosocial support is urgently needed to draw much needed attention to the identified needs and strengths of women, and for the recognition of psychosocial health and well-being as an area of concern. We hope through the weaving together of women's voices in this research, there will be knowledge translation and consciousness-raising between researchers and participants which will contribute to national debate on health and inform health policy and practice.

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## **Stressors, Coping, and Social Support Among Women in Papua New Guinea**

Rachael Hinton and Jaya Earnest

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## Abstract

In this study we used an interpretive, ethnographic, qualitative approach to examine Papua New Guinean women's narratives and perceptions about their health and the ways in which these were linked to coping with personal adversity. Women used a variety of strategies to cope with psychosocial stressors and challenging life circumstances, including both reliance on their own agency and active efforts and the seeking of social and spiritual support. We observed that limited access to social and economic resources, combined with gender constraints, made women socially and culturally vulnerable to social strain that affected their physical and emotional health. A number of women used avoidance strategies that were related to lower levels of self-esteem and life satisfaction and displayed high levels of anxiety. We propose the need to understand the context in which coping takes place and to enhance resilience strategies used by women in developing countries such as Papua New Guinea to manage the multiple stressors associated with confronting life's challenges.

## Keywords

coping and adaptation; psychosocial issues; qualitative methods, general; social support; stress; women's health

A body of evidence is emerging which shows that social support in private life and social interaction in wider social networks contribute to a person's coping ability and is beneficial to health, whereas social isolation leads to ill health (Cattell, 2001; Leipert & Reutter, 2005; Schulz & Lempert, 2004; Shaw, Dorling, & Smith, 2006). Social support and integration in social networks provide opportunities for influence, social engagement, and access to resources and material goods (Berkman & Melchior, 2006). Access to these social resources has been shown to be less prevalent among individuals with low socioeconomic status (Kristenson, 2006; Polakoff & Gregory, 2002; Walters & Charles, 1997). In assessing the impact of support on health, it is important to recognize that relationships can be either positive—intimate, nurturing, and supportive, or negative—conflicted, demeaning, and hostile (Berkman & Melchior, 2006). There is evidence to suggest that these negative aspects of relationships can have a very powerful and damaging effect on health, perhaps even to a greater degree than the positive aspects have on health promotion (Karlsen, Idsoe, Hanestad, Murberg, & Bru, 2004; Stansfeld, 2006).

The relationship between access to social, cultural, and emotional resources and women's health and vulnerability to risk has been examined previously (Leipert & Reutter, 2005; Moss, 2002), and social barriers that leave women in unsupportive environments, struggling alone, have been identified. Women who live in poverty have few choices

about where and to whom they might turn for support, advice, information, and assistance. Women who are more isolated, with restricted options and limited control over resources, tend to have greater health risks and less ability to deal with those risks (Leipert & Reutter, 2005). Multiple-role demands on women in most developing countries and rural economies leave little time for building community networks and social contacts. Social support can help reduce the sense of dealing with life's challenges alone (Polakoff & Gregory, 2006). Inequity and deprivation have damaging effects on health, and isolation is seen as a compounding factor that can make it worse (Cattell, 2001).

Widespread gender inequity leaves women and girls particularly vulnerable to abuse, exploitation, and violence in Papua New Guinea (PNG). Violence against women is characterized by domestic and family violence, rape and gang rape, and the torture and murder of women suspected of sorcery (Amnesty International, 2006; Australian Agency for International Development [AusAID], 2008; Garap, 2004; Toft, 1986). Early marriage, repeated childbearing, and heavy manual labor all have an impact on the health

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of women and their families (Gillett, 1990; Groos & Garner, 1998). Family and kinship are fundamentally important in PNG. Eighty-five percent of the population is rural and people tend to live in villages with close relatives. Men in PNG do not usually participate in household chores, agricultural production, or child care, as these are considered to be women's tasks. Polygamy is prevalent and fuels violence in communities (Haley, 2008; Toft, 1986). The practice of bridewealth (otherwise known as brideprice), a customary practice to unite two families and respective clans in enduring relations of obligation, is often construed to signify ownership and to legitimize a man's "right" to physically punish his wife when she is not performing her duties, or to demand certain services not included in traditional obligations (Macintyre, 2000, n.d.; Toft, 1986; Wardlow, 2006).

Women advocates in PNG and wider Melanesia (Jolly, 2000) increasingly argue that these practices are oppressive and reinforce widespread expectations of patriarchal dominance and male control over women (AusAID, 2008; Macintyre, n.d.). Customary patrilineal inheritance practices deny women land rights, and unstable marital and familial relations restrict women's access to resources. This creates a level of economic dependence and vulnerability that contributes directly to women's inability to assert control over their lives (Freedman, 1999), and has been shown to contribute to the increase in HIV/AIDS among women (Gupta, 2002; Hammar, 2008). In Papua New Guinea the political landscape is dominated by men, and only four women have been elected to Parliament since independence in 1975 (McLeod, 2002; Standish, 2007).

Poverty confronts people globally with a multitude of psychosocial and material challenges linked to social status, isolation, and lack of control over life circumstances. Such stressors challenge an individual's ability to maintain emotional well-being and can lead to poor psychosocial and mental health outcomes. Lack of resilience to stress associated with low socioeconomic status is a contributing factor for health disparities. An individual's perception of and attitude toward stress exposure is dependent on her or his social status (Kristenson, 2006). People who are marginalized and impoverished are more vulnerable, tend to have more negative exposure, less resilience, and fewer protective resources. People who have more resources in terms of knowledge, money, power, prestige, and interpersonal resources such as coping strategies, social networks, and social support are better able to avoid risk and adopt protective strategies when necessary (Link & Phelan, 1995; Solar & Irwin, 2007). Thus, no matter what the current profile of diseases and known risks happen to be, those who are best positioned with regard to important social and economic resources will be less afflicted by disease and psychological problems (Shaw et al., 2006).

Individuals can apply a number of different coping mechanisms such as problem-focused (task-oriented) and emotion-focused (emotional, avoidant) strategies to deal with life challenges. An individual's choice of coping modality is dependent on the situation, with usually more than one strategy being applied over time (Kafanelis, Kostanski, Komesaroff, & Stojanovska, 2009). Coping is associated with feelings of having control over one's life; power and optimism; the expectancy of a positive outcome; and seeing stressors as challenges rather than threats. As stressors occur, depending on one's view of the impending threat and the resources at one's disposal to handle the threat, one might or might not be overwhelmed (Utsey, Ponterotto, Reynolds, & Cancelli, 2000). As noted by Kristenson (2006), because the available resources are unequal in distribution, persons higher up the social hierarchy have greater levels of coping ability. Personal psychosocial resources, particularly a person's capacity and agency to cope with and feel control over life circumstances, are important mediators of health. The inability to cope leads to strain, frustration, and finally, helplessness and hopelessness; however, there is little research examining coping strategies used by women in resource-poor countries to manage the stress associated with confronting life's challenges.

The aim of this article is to describe the factors that contribute to variation in rural Papua New Guinea women's psychosocial adaptation to adversity, and in particular their ability to cope with and develop strategies to manage experiences associated with poverty, inequity, and a lack of resources. In this study we drew on women's voices and narratives to understand the ways in which life challenges affected their health and well-being. The women shared ways in which they accessed resources necessary to build agency and protect health. The strategies the women used to meet those challenges and maintain their health were explored.

## Method

The study was based on ethnographic and interpretive qualitative fieldwork conducted with 70 women in the Wosera District, East Sepik Province of Papua New Guinea, from mid-2005 to early 2006. The Wosera is part of the Abelam ethnolinguistic group, which has a population of more than 100,000 people and occupies an area between the Prince Alexander Ranges and the Sepik River. The Wosera is situated in the central and southern part of Abelam territory. The background information for this article was drawn from community-based research on women's perspectives of their health and barriers to good health across their lifespan. Young, adult, and older women repeatedly emphasized economic constraints and unsupportive relationships as their main barriers to good health. We examined

the impact of these challenges on women's lives and health and identified the resilience factors and the main modalities of coping that women used in response.

The culturally sensitive nature of the study led to a multi-method, interpretive, qualitative approach, underpinned by the critical theory perspective (Denzin, Lincoln, & Smith, 2008). The critical theory perspective implies that reality is shaped over time in many contexts and constructs by social, political, cultural, and gender factors, as was the case for the women participants of the study. In using these methods we created the opportunity for shared dialogue between researchers and participants. The semistructured questions focused on strategies used by women to overcome economic and social barriers to health, and documented intricacies of their lives (Denzin et al., 2008). We also documented the resources that were available to women to protect health and to overcome identified stressors.

### Setting and Participants

The Wosera district is one of the least developed areas of Papua New Guinea, and women's health and social development are no exception. In 2004, antenatal coverage in the Wosera was recorded at only 48%, below the national average of 58% (World Health Organization [WHO]/Western Pacific Regional Office [WPRO], 2008). Only 12% of births in the Wosera had a skilled attendant at delivery (National Department of Health, 2005). In 2000, only 43% of the women in East Sepik were literate, which was lower than the national rate of 46% (National Statistics Office, 2002). There is a heavy reliance on subsistence production for household consumption, limited cash earning opportunities, and low per capita incomes (Curry, 1999; Curry & Koczberski, 1999). A structural adjustment program in the last decade has contributed to a rise in the user-pay system,<sup>1</sup> and has had an adverse effect on access to education and health services throughout the country.

We conducted the study with 33 young women (18 to 24 years), 27 adult women (25 to 44 years), and 10 older women (older than 44 years). We selected participants using opportunistic, purposive, and snowball sampling methods (Patton, 2003). Women were identified following a community information session and through word of mouth by study participants. The first author carried out interviews in *tok pisin* (Melanesian pidgin, the lingua franca of PNG), with the assistance of a female research assistant and a female field assistant, both from the Wosera, who also acted as cultural interpreters. The research assistant led interviews with older participants who preferred to speak their local language (dialect of the family of *Ndu* languages).

Young women had an average education level of Grade 6, compared with an average of Grade 4 for adult participants and Grade 1 for older participants. One third ( $n = 11$ ) of

young adult women were married, and 9 of these young women had one or more children. The majority of adult women were married and had an average of four children. Half ( $n = 5$ ) of the older respondents were widowed. Most participants married within, or close to, their village of origin. Five (45%) of the married young women were from another village, generally within 1 to 2 hours' walk. Of the 27 adult women, 10 were from neighboring villages and 1 was from a village within an hour's drive. Of the 10 older women interviewed, 8 had married within their village of origin and 2 were from neighboring villages.

**Ethical considerations.** Ethical approval was obtained in accordance with the requirements of the Human Research Ethics Committee at Curtin University and the Papua New Guinea Medical Research Advisory Committee. To ensure anonymity, pseudonyms are used throughout this article. The participants were informed of the purpose of the study before discussions took place, and were assured of confidentiality. They were also informed that they could withdraw from the study at any time. We were also aware of our own positions at all times. The first author, who undertook the research, lived and worked for several years in PNG, is sensitive to the context, understands and speaks fluent *tok pisin*, and was aware that she must present narratives that were embedded in the women's voices and in the landscapes in which they live. The second author is from the developing world and works extensively with women and youth using participatory and empowerment methodologies.

### Data Collection

We used multiple ethnographic, qualitative methods to capture women's strategies for coping with health-related challenges within the social context in which health was experienced (Wadsworth, 2000). By using different data collection techniques embedded within an ethnographic and interpretive framework, we were able to draw attention to diverse perspectives, draw conclusions from a synthesis of the results, and validate the data through triangulation. We placed the focus on the participants' own perceptions and interpretations, and explored the complexities and meanings of their experiences and views in a natural and informal setting (Liamputtong & Ezzy, 2005). In addition, we used these methods so as to not discriminate against illiterate and vulnerable participants, an important consideration in this context because of the high illiteracy rate (Kitzinger, 1995). We conducted 31 in-depth interviews, (10 young women, 11 adult women, 10 older women), 4 focus group discussions, and 4 listing and diagramming exercises to identify and rank health priorities. We also used photo narrative exercises with 2 groups of young and adult women, respectively. Decisions about groupings were driven by the sampling process,

which allowed women to select their own group based on age, types of social relationships, and shared experiences.

*Focus group discussions and in-depth interviews.* We used focus group discussions because they provide the opportunity to stimulate discussions and interaction between a relatively small number of people from a similar sociocultural background or a preexisting cluster such as friends or classmates. It is a characteristic of focus group discussions that they are focused on an area of interest, and researchers try to get a good idea of how people think about a series of issues (Whittaker, 2002). Pini (2002) noted that as a technique, focus groups provide opportunities for reflection and examination of subjective experiences of everyday life that rarely exist for women. Four focus group discussions were conducted, two each with young women and adult women, respectively. Three groups had 6 participants and one group of single young women had 10 participants. Focus group discussions lasted for 2 hours, on average, which reflected the need to balance sufficient time for covering the main themes with moderator and participant fatigue, interest, and workload demands (Pini, 2002; Rice & Ezzy, 1999). Because of the localized setting of the research, all of the participants were known to each other. Conversations flowed freely and participants were willing and felt supported to disclose their concerns about polygamy, contraception, and violence against women among friends and family. There was a sense of camaraderie in the group, shared empathy, and commonality in experiences.

All focus group participants were given the option of an interview with the first author. On several occasions women asked the researcher for a one-on-one interview to present their point of view about sensitive issues (being a second wife or domestic violence) which might have been difficult to highlight during group discussions. On average, interviews lasted 1 hour. A focus group was also held with 6 young men and 8 adult men to consider men's perspectives of the main determinants of women's worries and concerns, and to gauge how they saw themselves in relation to women's health. This was important given that the women identified their relationships with men as central to health.

*Photo narratives.* Photo narrative exercises were similar to focus group discussions. Photographs of Papua New Guinean women from a similar cultural context and at different stages of their lives (child, adolescent, adult) were shown to participants and used to guide the discussions. Visual methodologies are becoming more common in social research, encompassing media such as film, video, still photography, electronic visual media, and material artifacts (Guillemín, 2004). We used photo narratives for the extra dimension they could add to data collection methods. The narratives provided a common point of interaction among women and encouraged lively discussions as women deliberated and ascribed life experiences to the subject of each photo. Participants could talk about

themselves in the third person and use the subject of the photo as a point of reference on which to conceal their embarrassment or to base a sensitive point of view (Ulin, Robinson, Tolley, & McNeill, 2002).

*Participatory diagramming.* The participatory diagramming technique of ranking and scoring was employed, as it was seen as an effective means for women to prioritize, compare, and discuss their main health issues. Most of the women who participated in a focus group discussion or a photo narrative exercise also participated in a participatory diagram exercise. This enabled us to gain feedback on some of the preliminary findings and continue to engage women in the research and analysis process. As much as possible the participant groupings for the participatory diagramming exercises were kept the same as for the focus groups and photo narrative exercises.

*Narratives and storytelling.* Narratives and storytelling are important social and cultural tools in most indigenous and rural cultures, and these techniques were used during group discussions to elicit descriptions and stories from participants based on their experiences and real-life situations. Through their storytelling, women were able to interact and create engagement with other participants using metaphor, rich imagery, suspense, and emotion (Greenhalgh, Collard, & Begum, 2005). It allowed participants to share personal, often intimate aspects of their lives and relive past experiences (Corbin & Morse, 2003). As used in critical qualitative research, the stories created space for dialogue. Through their stories the women in this study discussed their hope, displayed unique agency, and shared how they healed (Liamputtong, 2007; Sangtin Writers & Nagar, 2006).

*Rigor.* Triangulation was achieved by multiple data collection methods. This allowed for within-methods triangulation and cross-validation of the data, thereby reducing the possibility of bias and increasing the richness and rigor of the data obtained (Denzin & Lincoln, 2008; Hesse-Biber & Leavy, 2006). To ensure that cultural understanding and meanings were accurately interpreted, all data were discussed with the local field assistant. The use of cultural interpreters increased reliability of the data collected and revealed cultural nuances in analysis. Internal validity in qualitative research is a process of exploring alternate explanations for observed events. Validity was enhanced by member checks with key informants, and expansion or clarification of issues that emerged during data analysis (Sharts-Hopko, 2002). An audit trail, as discussed by Patton (2003), was also established, ensuring methods and data were documented so that the analysis of the data could be confirmed and replicated by other researchers.

## Analysis

Data analysis was an inductive process conducted throughout the course of the study. All in-depth interviews, photo

narrative exercises, and focus group discussions were audio-taped and transcribed verbatim for analysis. Detailed notes were taken during participatory diagramming to support the visual and interactive dimensions of the exercise. We initially read, reread, and discussed the transcripts and field notes taken during data collection to become familiar with participants' experiences and meanings as described within the circumstances of women's lives (Dageid & Duckert, 2008). This helped to immediately identify the emerging themes, unanticipated findings, and gaps. To identify general ideas and themes, we applied a code to sentences and paragraphs related to descriptions of women's perceived stresses and their pattern of coping in their multiple roles. This was done by the first author, together with the local research assistant. This helped to guard against cultural misinterpretations (Goodman, 2004). By identifying how commonly themes occurred in the data it also became clear whether certain themes tended to emerge in specific populations (young women for example) or more generally across groups. The common data for each identified theme was treated as the unit of analysis. The computer software program Atlas.ti version 4.1 (Muhr, 1997) was used to manage the data analysis process.

Throughout the data analysis we grappled with the nuances and lenses of appropriate representation (Liamputtong, 2007; Sangtin Writers & Nagar, 2006) and the participants' shared meanings of poverty, worry, solutions to problems, and resilience. They openly voiced endemic financial difficulties and poverty, talked a great deal about worry and stress, and discussed avoidance behaviors, as well as personal strength and resilience factors and how they tried to address and cope with their problems. They openly discussed their experiences of seeking health services. We have addressed issues of equity, hope, and social justice in this article as the women interwove these within the stories of their lives. We have thus reexamined our research position embedded in different constructs, and applied it to the real-life situation in the non-Western context of rural PNG (Tomaselli, Dyll, & Francis, 2008).

### Limitations

Although the first author had lived in Papua New Guinea for more than 3 years at the time of the research, she was nevertheless from the West and was therefore considered an outsider. This might have influenced (both positively and negatively) the decision to participate, and might have affected the responses to questions. Women's strategies of suppression or reticence to breach confidentiality outside the family unit might have meant they were unwilling to disclose their feelings and experiences to a relative stranger. It might have also been an unfamiliar experience for women to be asked to express their own views about their health or emotional needs in their everyday lives, let

alone with an outsider. Given the practical considerations of women's workload obligations, group discussions were held on specific days chosen by the participants. On several occasions the nature of storytelling meant that discussions exceeded 2 hours and some participants became unsettled and tired, losing concentration and interest. Although the study time frame allowed some flexibility so that the discussion could have ended and resumed on another day, women's time and workload obligations did not.

## Results

In the following discussion we examine the different ways women dealt with daily challenges and psychosocial stressors throughout the lifespan. We examine women's specific coping responses, personal psychosocial resources, and access to social support in light of the realities of women's lives. Participants cited economic constraints, heavy workload demands, and unsupportive relationships as their main stressors. Limited access to social and economic resources, combined with gender constraints, made women socially and culturally vulnerable to social strain that affected their physical and emotional health.

### *Coping With Economic Constraints*

Confronted with difficult life conditions, the women in this study tried new strategies and enhanced existing strategies to maintain their health and well-being. The most common theme to emerge in discussions of women's coping strategies was that of being self-reliant and confident in their own abilities to meet economic demands and provide for their family. Sally's self-esteem and sense of security in her own capacity to earn an income and to meet the daily subsistence needs of her family contributed to the strengthening of her mental and physical health:

If you are a woman and you don't work in your garden and you only look to your husband to provide, you will worry, feel sorry. If you are a woman who works in the garden, or you go to the market to earn money then you won't feel worried or sorry. Then you will be healthy. For example, your house will have enough food.

Single and married women could rely on their immediate family, in particular their "blood relatives"—mother, sisters, and brothers—for financial support. A very small number of adult women expected their husband to be the main economic provider for the household; however, most respondents portrayed a coping style that was based more on self-reliance than dependence on others. Hattar-Pollara, Meleis, & Nagib (2003) report that women often take it on themselves to tackle their own problems without expecting



or seeking the help of others. This was a prevailing theme for women's coping patterns. The most common statement heard was "*mi meri blong maket*" (I am a woman who [sells produce at] markets), and underlying this was a sense of their own self-reliance and independence, as conveyed in this comment from a young woman: "If I go to the market, I will be able to look after myself. Otherwise, where will I get money for food, soap, and kerosene?"

Trudi admitted that to find money to meet material needs a woman had to "work hard. If you work hard to make a garden, harvest the food and sell it and make some money, then you will survive." A constant worry in all of the women's lives was the economic burden of meeting domestic and social obligations. Women reduced this worry and anxiety by using their initiative and by being resilient in stressful encounters as they unfolded. They sold garden produce (bananas, coconut, peanuts, sweet potatoes, corn, and betel nut), cooked food (doughnuts, smoked fish), or sold other small items (cigarettes, candy) at local markets to meet domestic and household costs. This was the main source of income for the majority of participants, and many women planned ahead, planting crops specifically for sale. A small number of women looked to meet gaps in the market by selling second-hand clothes (purchased in a bale from Wewak, the provincial capital), or by sewing clothes for sale. A significant initial outlay was required to purchase a sewing machine (\$75 US) or a bale of second-hand clothing (\$100 to \$150 US). Unless the amount could be borrowed from family members, these were not affordable alternatives. For some participants, the harvest and sale of cash crops, such as cocoa and vanilla, provided an additional means of income. During the study period the price of vanilla had dropped from K600 (\$200 US) per kilo to K8 (\$2.60 US) per kilo, and cocoa, which had been selling on the international market for K6.50 (\$2.20 US) per kilo in 2003, had dropped to around K4.50 (\$1.50 US) per kilo. Women sold vanilla or cocoa as a supplement to market sales and on a needs-only basis; doing this, it was possible to raise enough funds to purchase a number of household items such as a can of fish, laundry soap, and a bag of rice.

An adult participant explained that a woman would experience frustration and resentment if she depended entirely on the will and cooperation of others to meet her needs. A reliance on relationship dependence would result in arguments, relationship instability, and ultimately a poor sense of well-being. Women valued their role as "the glue that kept the family together." Their own worth was enhanced if their productive capabilities contributed to meeting familial and communal obligations; however, participants were very aware of and vocal about the unjust division of labor. A woman who did not work hard to provide material and financial support for the household

(as well as share resources with the wider community) was seen to be deficient in her role as wife and mother. Women often face strong societal expectations to fill a compliant and subordinate female role (Dageid & Duckert, 2008), and going directly against patrilineal structures was difficult. "Inventive copers," as described by Kafanelis and colleagues (2009), are aware that life circumstances have become confounding factors in their current experience, and in response they adapt to changing situations and environments. The women in this study reflected on the cultural prescriptions of their role and did what they could to mediate and mitigate the negative effects:

If you wait for your husband to give you money you will be frustrated and angry. You won't have money to buy kerosene or to buy soap to wash your clothes. When others see you, you will look dirty.

A dependence on personal psychosocial resources was intrinsic to all accounts across the lifespan. Young, adult, and older women expressed the importance of self-reliance and the ability to make the best of available options and resources to gain some control over life circumstances. Barbara could rely on a variety of options for raising an income, and compared with other respondents she conveyed less anxiety associated with meeting her daily needs:

I sell second-hand clothes, I sew clothes, and my mother also gives me money that she earns from selling food at the market. I have plenty of work on the side so I don't worry about money.

A strategy several adult women used to alleviate their financial concerns was to budget and save for future expenditures, such as school fees or brideprice contributions. A widowed adult woman discussed her strategy for raising the brideprice for her son's impending marriage, a cost of approximately K1000 (\$330 US). Reciprocity and the sharing of resources and wealth to support the aspirations and obligations of the kin group and clan is a significant cultural practice and obligation in Papua New Guinean societies. She relayed how during the previous few years she had contributed to many family and customary obligations (such as brideprice and funeral payments), and social activities, and now it was time for her to call in her debts. She had found this to be a risky strategy, because by investing in customary relationships rather than saving the money herself, she had pinned her hopes on other people fulfilling their social obligations to reciprocate. At the time of the study she was extremely worried that her contributions would not be fully reciprocated. Without a husband to negotiate additional repayments, she believed she would be unable to meet the cost of the brideprice.

With access to money, women were in a better position to access the psychosocial resources necessary to protect health. Women conveyed that they felt less anxious, insecure, and isolated, and that they had some degree of control over the conditions of their lives. With money a woman could fulfill some of her more pressing domestic and familial obligations. She was able to purchase fresh produce, protein such as tinned and smoked fish, and other household necessities. Some young women placed high hopes in the freedom money would give them to “*go raun long taun or wanem hap mipela laik go*” (go to town or wherever we want to go). For young women still in school, it would allow them to complete their education and assure them a more certain future. This future involved significant improvement in access to social and economic opportunities outside of the village. Money also gave women access to a wider social network. They had a reason to go to the market and socialize with others. The weekly market was a significant social activity and an opportunity to meet with friends and family. On most days, a heavy household workload and child care duties prevented women from meeting friends and family; it was therefore both isolating and frustrating for young and adult women to remain at home on a market day.

Women experienced an enormous burden to provide funds for household necessities, children’s school fees and associated costs, and to meet cultural obligations and contributions. Women utilized different modalities of coping and accessed a variety of resources to manage challenging circumstances (Kafanelis et al., 2009). As discussed elsewhere (Ching, Martinson, & Wong, 2009), the objective for coping was to get problems under control through directive efforts and the social support system:

Everything needs money. On the physical side, like food, we can do the work ourselves and the food can grow and we can eat. Everything from the store and other big things such as brideprice and school fees need money.

### *Coping With Unsupportive Relationships*

Social relationships are not necessarily supportive and can sometimes become a stressor. When social relationships are experienced as negative, they affect a person’s ability to cope (Karlsen et al., 2004). Many women in this study discussed experiencing unsupportive marital relationships, represented by a lack of emotional, social, and economic stability. Women experienced a heavy and unequal workload burden and were typically responsible for domestic production and all childrearing activities; they were resolute in their belief that this burden was a direct result of being female. The relationship between a woman’s heavy

workload and an unsupportive husband or unsupportive parents emerged as a common theme. Respondents talked at length about their attempts to deal with unsupportive relationships. Women’s main coping strategies included problem solving and seeking social support, although some women described their reliance on passive emotion-focused coping, such as denial, resignation, and mental disengagement.

The majority of women used task-oriented coping styles to deal with unsupportive relationships and manage economic and workload stressors. Most women could access material resources, such as land and markets, and turn to social resources for instrumental (assistance with funds or workload demands) and emotional reasons (someone to talk to). They planned and were systematic in their approach to meeting their workload and economic needs. However, multiple workload demands put many women at increased risk of psychological burnout, which could impinge on their ability to adapt to stressors in the long term (Karlsen & Bru, 2002). The choice of active, problem-focused coping strategies (education, employment opportunities, welfare) aimed at altering life circumstances available to many Western women was limited for the women in this study. With restricted options to change their situation, the consistent use of problem-solving and task-oriented strategies could result in distress, arguably more than emotion-focused efforts, such as avoidance and denial (Dageid & Duckert, 2008). Women expressed resignation, frustration, and anger about the constant pressure of their role and the heavy burden of meeting their responsibilities in an unsupportive environment: “Sometimes you can make a joke about how you feel or you can get angry. When you get cross and you let it out then you will feel your anger go down.”

Several respondents discussed “giving up,” or “just trying to forget” as a way to cope with unsupportive relationships and marital conflict. Many respondents chose at times to cover up (hide) how they felt about their heavy workload burden and discord in their relationships. They described their hurt, anger, resentment, frustration, and despair, and the ways in which they kept their feelings to themselves to avoid a fight and maintain their self-respect. They described using strategies to help them endure the constant worry, to not complain and to accept their circumstances, knowing there were no better alternatives (Hattar-Pollara et al., 2003):

I keep my problems to myself. I just ignore my husband. I eat and then I just go to sleep.

When I am really worried and think a lot I cry. So I pray, that’s the one way I know, that God will give good thoughts to my family so they will treat me better.

Other women tried to address hostile relationships by withdrawing and “going on strike.” This could range from a woman refusing to talk to her husband to leaving him in charge of the household for several days:

Some women will sit down and not say a word. They won't say a single word. Then you will realize that she is angry. Some women have this kind of attitude. This is the way they will show you they are cross with you.

Young women described withdrawing entirely, and running away was a strategy used to deal with parental neglect or marital abuse. Leaving the marital or parental home was an extreme measure that indicated a high level of stress and discord that could no longer be tolerated. For many women it was a means of self-preservation. Some married women could seek refuge in the home of their biological kin to engage broad support and have the dispute mediated on their behalf. These methods provided women with short-term emotional relief, but were inadequate for the long term; for example:

I don't feel good. It is his bad attitude and behavior that makes me leave him. I go on strike for one or two weeks. I won't give him food. I will walk around aimlessly. I will come here [to the house of my cousin] to eat, or to my parent's house.

Several women experienced chronic violence in their marriages and preferred avoidance coping in response. Confrontations had become so costly in terms of time and energy that withdrawal or acquiescence had become a practical and safer option. These women felt powerless to modify or improve their situations. They did not have the familial support or opportunity to leave violent relationships permanently, and they responded to their mistreatment with extreme passivity or by contemplating suicide:

My head hurts. When I see my husband I say to myself, “Forget it. I'm just going to get some medicine and kill myself.” I get these kinds of thoughts, because of my husband.

Sometimes if a man leaves his wife for another woman, his wife won't be able to think straight. Her heart is broken. You will feel like you want to die. I will kill myself. I will hang myself from a tree. Some women overdose to commit suicide.

Individuals who use avoiding coping strategies—such as distraction or daydreaming—and are unsuccessful in dealing with their stress, can develop symptoms of

depression (Welch & Austin, 2000). Several women in this study recalled severe signs of anxiety that included fainting, sleeplessness, and inability to concentrate. Some respondents felt inadequate and powerless to deal with their marital relationship in a problem-solving manner. The respondent who expressed the first comment below displayed a significant level of resignation about her situation:

How will I fix it? It's not as if he is a small child. How will I fix the problem, because he smokes marijuana as well?

It's our problems that cause us to walk around like a sick woman. You won't look smart or you won't be active. People will see you and ask if you are sick. And you will lie and say, “Yes, I'm sick.” But it is worry.

Several young adult women described worrying signs of anxiety related to their inability to deal with marital discord. One participant recalled the times she had collapsed because of the extreme worry and anxiety she felt about her marriage. Her fellow respondents saw her hopeless state as extremely damaging for her health: “Her husband is there but he doesn't help her with anything. She finds it hard to think straight. She gets confused and feels dizzy and she collapses.” There were clear links between psychological and physical morbidity (Dageid & Duckert, 2008). In extreme cases, participants believed severe distress could result in a woman's death:

If I think too much about my problems or when I work and I worry at the same time, I think that my worry can kill me. So I try not to work too hard, think too much, or argue with my husband. I just keep it to myself.

Strong negative feelings and distress were considered contrary to women's attempts to persevere in difficult conditions and to maintain a good sense of individual and family health and well-being:

We aren't happy, we feel worried. Sometimes when we are worried we have headaches. And because of this we get confused and we have a lot of negative thoughts and so we take it out on our children. We chase them, tell them off for no reason, we get angry. This happens to us as mothers. We face a lot of problems.

Sometimes I am worried. I think too much about things and the worry makes me sick. If I worry too much, worry can make me sick, too. So because of

that I make sure that I don't worry too much. If I am worried today, by tomorrow my worry will have finished. If I worry too much, for many weeks, or five days, one week or two weeks, then sometimes you will become sick. If you worry, you know that, if you worry too much it will kill you. Some days these thoughts come, worry comes, but the next day we will have good thoughts again. We get up and we go and do the work ourselves. We have to forget our worries.

### Seeking Social Support

Social support is an important resource that has been shown to have a positive impact on well-being and to reduce the negative effects of stress (Karlsen et al., 2004; Nazroo & Williams, 2006). Social support has a protective effect by decreasing or preventing the risk of illness (Stansfeld, 2006), and has been associated with high rates of disease-related coping (Curtis, Groarke, Coughlan, & Gsel, 2004). The women in this study recognized that family support and positive family interactions, with their husband, in-laws, and kin group, were invaluable for helping them cope with psychosocial stressors. The effect of social ties and support networks on the women's health was dependent on a variety of demographic and contextual factors, including age, village of origin, marital status, access to land, and position within the household. Women who experienced supportive family interactions and could access support from friends had the opportunity to talk and think about how best to handle a problem. Social support had a buffering effect, which helped to moderate and mitigate the impact of acute and chronic stressors on health (Stansfeld, 2006). A lack of support resulting from social isolation and spousal or familial restrictions had a direct impact on the women's health. Women with limited social support expressed their hopelessness and helplessness to manage or avoid psychosocial stressors. They had low feelings of self-worth and a poor sense of well-being:

When I sit down with my sisters-in-law and my husband's brothers, they don't talk in front of me. They talk behind my back. My head feels heavy because of this. I don't talk to them. I don't feel happy.

When I work I feel worried. I'm not from this village. I wanted to get married and I came here. But I don't have sisters here, or brothers to help me. Who will help me, as I'm not from here?

The parents of a young adult woman had died, and because of her restricted social support network she found it difficult to cope with the changing conditions of her life:

I look at the girls my own age and they have their parents to look after them. Their parents help them in their gardens. Or their brothers help them. I don't have this kind of help. Every time when I have a lot to do, I continually think about my parents. This is what I think about the most.

For most adult respondents, religion was a source of personal comfort. It provided meaning and balance in the women's lives and gave them a sense of control over difficult life circumstances. It was also a source of social and cultural connection, and the women were able to develop and enhance friendships with likeminded women. Respondents described how they depended on their spiritual beliefs for guidance and strength of will when dealing with personal and social hardship. Religion provided a framework for women to think through their problems, and with which to measure or improve their own or their spouse's behavior. It gave many women the strength to identify more active coping strategies, boost self-esteem, and promote positive self-appraisal. Although women's religious beliefs promoted strength and internal resources for coping, prayer was used by some women when nothing else could be done to alter or modify their conditions. During a focus group discussion an adult woman shared that prayer helped her to endure difficult times, but clearly the underlying stressor remained:

I pray and then I have better thoughts. Like, about my marriage. I have these problems. The father of my child didn't look after me so now I live with my brother, my mother. I think about these problems too much so I pray. I pray and God helps me. Good thoughts come to me.

### Sharing Life Experiences as a Means of Coping

The women in this study sought social support for practical and emotional reasons. Most women said they could talk about their problems with either a family member or a close female friend. They were given advice on ways to solve a problem, and they received necessary support to boost their self-esteem and confidence. A trusted blood relative, a sister, an aunt, or a grandparent was identified as a common source of support, and for young women in particular, friendship networks and close, personal relationships were seen to be beneficial to health.

Depending on the issue and the type of social support required—whether practical, emotional, or both—respondents evaluated the most suitable option for support. For example, a young woman related that she could talk to her brother and sister-in-law about arguments with her parents, but would only talk to her girlfriend about



boyfriend-related issues. Many older women talked to their children and to trusted women of the same cohort who were experiencing the same disabilities and health problems. Other older women simply kept their problems to themselves, prohibited by their children to divulge their concerns to others because it would be seen to reflect badly on their family. Several older respondents mentioned that their only source of support was to pray to God for an imminent death:

I want God to do his thing so I can die. I want to see my relatives who have died. When I go to the garden I think about them, and I cry.

Several adult women who had been neglected or abandoned by their husbands sought support in church networks, with "women of similar experience and needs." These women struggled to acquire resources to support themselves and were solely responsible for their family's sustenance. They therefore helped each other with workload obligations and could be relied on for emotional support when they were the target of unwarranted gossip, generally related to suspicion of an extramarital affair. These female friends were valued for their candid and genuine contribution to the social support experience.

### *Adverse Effects on Coping and Seeking Social Support*

Various contextual (gender roles, financial constraints, production, and child care demands) and personal (self-esteem, adaptability, attachment to others, spiritual values) factors affected the women's ability to access the resources necessary to protect and enhance health, and had an impact on women's ability to cope. Women's access to income-generation opportunities were few, and only one adult woman had the means with which to diversify outside of market sales. The women in this study were also restricted in the resources that they could draw on for support. A heavy workload, familial obligations, and a husband's control over his wife's movements restricted a woman's ability to socialize and make social contacts. Husbands were seen as unsympathetic, a threat, or the cause of their problems, and health workers were rarely cited as a source of help or support. Because several participants had married outside of their village, distance played a part in restricting their access to natal kin and wider support networks.

The most common reason given for not seeking social support was embarrassment or shame. A frequent comment made by respondents was that problems inside the immediate family should stay within the family, and because of this the women chose to keep their problems to themselves. Women concealed their pain and internalized their

problems. Consistent with the findings of Walters and Charles (1997), women were trapped by a coercion of privacy. They were expected to succeed and be seen to be managing in the role of wife and mother despite the difficulties faced in meeting often impossible demands. If a woman did talk to others about her problems, she left herself open to suspicion, people could *tanim tok* (change what was said) and *tok beksait* (talk behind a person's back). This could result in violent consequences.

A lack of anonymity and risks of breaches of confidentiality were therefore a major hindrance to women seeking social support. The respondents lived in a very small community in which most people were related, and as a result women were aware that *toktok bai muv* (what was said would be spread). Most respondents were hesitant to talk about their economic concerns with individuals outside the immediate family, in case their conversation was misconstrued. If a woman was suspected of asking for money, she would be seen to "have no shame" or self-respect. Some respondents reflected that in some circumstances they could not even trust members of their own family. A young woman said, "I can ask for my sister-in-law's advice, but I could never share my secrets," because the information could be passed to her brother, whose role it was to "discipline her" if she defied traditional customs. During a focus group discussion, a widowed adult woman admitted that she rarely looked to her two married sisters for support in case they suspected she was seeking the attention of their husbands. Her sister, who was also a participant, concurred with the comment.

### **Discussion**

Numerous social, cultural, and economic factors contributed to these women's psychosocial adaptation to different life challenges and their ability to develop strategies to cope in response. Comparing the findings of this study with the findings of other studies on the coping strategies of women in other non-Western settings (Ching et al., 2009; Dageid & Duckert, 2008), we have shown that the coping process is highly context specific and related to an array of personal, cultural, and social factors. The women's choices of coping strategies were linked to the circumstances in which the strategies were employed and the purposes for which they were intended.

There was a resonance between the voices of the women in this study and the literature about women's health, and health and poverty (Avotri & Walters, 1999; Hildebrandt & Kelber, 2005; Schulz & Lempert, 2004). Unsupportive and unequal relationships and increasing economic demands saw women turning to their own active efforts, to spiritual and social support, and to the resources that could be mobilized within those networks, to maintain health (Schulz &

Lempert, 2004). Women described their efforts to avert the hopelessness and uncertainty that some respondents described experiencing.

Although a woman's health-related coping behavior was to some extent within her control, many of the social determinants of health were not. A woman's agency was constrained by the situations and statuses that were conferred on her (McDonald & McIntyre, 2002). However, consistent with the Melanesian context described elsewhere (Stewart & Strathern, 2000; Wardlow, 2006), the women in this study had the confidence to take personal responsibility for improving their conditions, and showed strong signs of self-assertion, self-worth, and independence in very trying circumstances. Respondents described a host of individual actions that enabled them to gain some control over their life. They relied on, but recognized the limits of, the resources they could access to sustain themselves and their families.

The problem-solving and task-orientated strategies discussed by the women in this study appeared to have a positive outcome. These strategies presented a pathway for the prevention of emotional distress and mental health problems among the women. Studies in other parts of Papua New Guinea have shown that when women earn an income from their own labor, they have more control over its allocation. The public recognition of their enhanced capacity to provide for their families also allows women to assert their independence and authority in support of the development of their families and communities (Koczberski, 2002). The development of livelihood strategies and credit and savings schemes in the Wosera could build on the existing skills, knowledge, and self-reliance of women, empowering them to tackle new challenges and increasing their self-esteem and capacity to care for themselves and their families. Positive intervention programs based on empowerment that target the psychosocial determinants of health would give women and men the capacity to handle exposure to stressors, not as problems but as challenges that could be overcome.

Consistent with the wider coping literature, our study findings showed that emotion-focused and avoidance coping was detrimental to psychological well-being and contributed to poor health. Evidence shows a significant relationship between emotive coping and negative outcomes (Curtis et al., 2004; Karlsen et al., 2004). Avoidance strategies were related to lower levels of self-esteem and life satisfaction, high levels of anxiety, and were consistently associated with poor social adaptation (Desmond & MacLachan, 2005). According to Reviere and colleagues (2007), women who experience intimate partner violence and have attempted suicide as a coping strategy are more likely to accommodate or placate their abuser, whereas other women report a greater tendency toward safety and

self-preservation, or try to identify ways to leave an abusive relationship. These women also utilize other positive coping strategies, such as seeking social support.

The reasons for avoidance coping by the women in our study were not always expressed, but might reflect long-standing coping patterns and the helplessness of women to deal with issues in a problem-solving manner (Welch & Austin, 2000). Participants shielded their emotions to avoid intensifying their oppression, and they emotionally or physically removed themselves from unfavorable circumstances. Utsey et al. (2000) showed in their study of the coping strategies used by African Americans to deal with racism that avoidance coping is preferred because a confrontational response can result in violent outcomes. It is therefore easier to withdraw and ignore the threat. The suppression of thoughts and emotions has been shown to be related to perseverance and endurance when an individual is confronted with trauma and adversity (Goodman, 2004).

Exploring the concept of resistance and agency among the Abelam, Scaglione and Norman (2000) reflected that in circumstances in which resistance has little effect, people simply opt out, achieving determination through avoidance. Thus, this type of strategy might reflect the social context as much as the needs of the individual. A thorough examination is required to ascertain whether avoidance coping is a form of resistance or is disempowering for women (Hattar-Pollara et al., 2003).

### *A Way Forward*

The protective nature of social affiliations and social support for health has been well documented (Desmond & MacLachlan, 2006; Stansfeld, 2006; Wilkinson, 2006). Social support is central to women's health and affects their ability to deal with risk and vulnerability. Physical and social isolation, limited options, and the undervaluing of women increases the need for social support. People who perceive supportive family behavior report the more frequent use of problem-focused coping styles. People with restricted networks are more likely to express feelings associated with negative health outcomes, such as anxiety and depression (Cattell, 2001). Poverty has a direct and negative influence on health, but isolation adds to the deterioration of health (Leipert & Reutter, 2005). Many women around the world, because of an array of social, cultural, and economic factors, are vulnerable to poor psychosocial health, unable to cultivate health-enhancing relationships or promote interpersonal connections (Karlsen & Bru, 2002; Moss, 2002; Niaz, 2003). The women in this study who had restricted social networks understandably found it more difficult to cope.

Preventive interventions and the provision of adequate support to improve women's coping strategies and resilience

at various critical stages of the life cycle, when its lack could lead to depression, might help women deal with life transitions. Learning to cope well as a young adult with life's changes and challenges or, alternatively, learning helplessness and hopelessness, has a decisive influence on adult coping experiences and to feelings of control over life (Kristenson, 2006).

Women in Papua New Guinea are part of a nexus of social relationships—between spouses, siblings, parents, in-laws, and others—and it is not surprising that this is the framework within which women expressed their struggles and their modes of coping. Efforts to involve family members in a supportive manner could help young, adult, and older women cope with psychosocial stressors and create a context of resilience. Health professionals should consider ways to educate family members and peers as sources of positive support for women, and effectively utilize these resources when planning health care programs for women (Karlsen et al., 2004). This is an issue requiring more research, and that has strong participatory action research possibilities.

The small number of women in this study who relied on avoidance were at risk of, or might already have had the symptoms of, depression. Depression and a low level of self-esteem are associated with psychosocial stressors, especially limited control over one's life (Welch & Austin, 2000). Because contextual factors have an immense impact on women's lives, they must also be taken into account in health care efforts (Dageid & Duckert, 2008). Health workers should assess for the symptoms of depression and be familiar with verbal and nonverbal behaviors that would indicate the use of avoidance coping. If women are struggling to cope with the demands of daily life, interventions must be aimed at getting women to talk about issues that are stressful for them. Health professionals must support individual women to reflect on their situation, allow them the freedom to examine their strengths and constraints, and develop the most appropriate coping strategy based on available resources. This is preferred over coercion and pressure to use measures that are seen to be adaptive (Ching et al., 2009; Reviere et al., 2007).

## Conclusion

Very little attention has been given to understanding the contextual factors that influence women's coping mechanisms in Papua New Guinea in relation to their health and well-being. An examination of the stressors women are exposed to, and that require them to use what we have shown to be a repertoire of coping strategies, is necessary for the development of effective interventions. This is specifically true in the light of how coping strategies are connected to a person's social circumstances, self-esteem, and perception

of quality of life. The women in this study resorted to a combination of problem-focused and emotion-focused coping when confronted with stressful encounters (Karlsen & Bru, 2002). Women's examination and interpretation of these stressors affected their use of coping strategies (Ching et al., 2009).

The women in this study dealt with their circumstances of deprivation, limited social support, and chronic uncertainty with determination and strength, vital resilience qualities related to the health of women living in poverty (Polakoff & Gregory, 2002). Psychosocial capacity is a significant mediator of the severe effects of poverty and discrimination; however, because women are exposed to chronic stressors that reflect their socioeconomic circumstances, there can be no substitute for a more equitable distribution of resources (Cattell, 2001). Thus, interventions aimed at enhancing coping strategies must be embedded in a broader strategy of structural change to create the opportunity for women to access the necessary resources to improve and gain control over their own lives (Kristenson, 2006). Government, civil society, and other stakeholders must build on, learn from, and systematically engage long-term with local initiatives and organizations that are driving socioeconomic change and promoting social justice in their communities (such as *Lus Fruit Mama* in West New Britain, Kup Women for Peace in Simbu Province, and Young Women's Christian Association [YWCA] in urban settlements). These organizations are working to address some of the core stressors that impact on women in Papua New Guinea, yet so far there has been no political commitment of action supported by funds to strengthen local efforts. Funding agencies, major donors, and the legal and education sector, in cooperation with relevant partners (non-government organizations, churches, private sector), must drive the process of policy and coordination at the national, subnational, and local levels that draw on the "voices" of rural women. There is a requirement to provide an environment conducive for change based on self-reliance, the value of participation, equality, and the use of local resources.

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## Note

1. In 1995 the government committed to a structural adjustment program (SAP) and key economic reforms, including trade liberalization and the imposition of higher fees for health services and education. This has undoubtedly had an adverse effect on access to education and health care throughout the country.

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### Bios

**Rachael Hinton**, MSocSci, is a doctoral candidate at the Centre for International Health, Curtin University of Technology, Perth, Western Australia, and currently works as a research advisor in Papua New Guinea.

**Jaya Earnest**, PhD, is an associate professor and postgraduate research coordinator at the Centre for International Health, Curtin University of Technology, Perth, Western Australia.

## **Appendix V**

### **Focus group discussion guide (Adult women)**

1. Tell me about everyday life. What is a woman's life like here?
  - Young women?
  - Married women?
2. In your opinion, how is life different for a woman than for a man?
  - Work
  - Responsibilities
3. When you say you are healthy, what do you mean?
  - What can you do to stay healthy?
  - What is the most important?
4. Do you often think about your health?
  - If no, what brings 'health' to mind?
  - If yes, what makes you think about it?
5. What are the (health) problems women (your age) face here? Physical problems?
  - What problems are worse than others? How?
6. Does your daughter (or mother) face the same problems as you?
  - If no, how are they different?
7. Is there something you do to overcome the problem of (name problem)?
  - If no, how do you think this problem could be overcome?
8. Who do you turn to when you have a problem? Why?
  - And when you are physically ill, who do you turn to?
9. Do you go to the health centre for some of your problems? What problems?
  - What has been your experience with going to the health centre?
  - Are there some services or advice from health providers that you would like?

## Appendix VI

### In-depth interview schedule (tok pisin)

1. Inap yu stori long mi long stap blong yu long olgeta dei. Stap blong yu em i olsem wonem?
  - Na long taim yu yangpela (yu no marit), stap bilong yu em bin olsem women? Wankain olsem nau?
  - Stap blong ol man emi wankain olsem ol stap blong meri?
2. Taim yu save tok yu “stap orait” (wun’ei yukunba yerik’wa), stap blong yu em olsem wonem?
3. Igat sampela samting yu laikim bai mekim yu stap gut?
  - Long laip bilong yu, yu ting wonem samting emi nambawan long mekim yu stap gut / orait?
4. Dispela kain tingting, olsem yu bai laikim long yu mas stap gut, yu save tingting planti tu long dispela?
  - Sapos yes, wonem samting imekim na yu gat dispela kain tingting?
  - Sapos nogat, wonem samting kamap long yu na bai mekim yu tingting long stap gut?
5. Wonem samting isave mekim na yu bai tok olsem yu no stap orait tumas? Ol meri save painim sampela bagarap long bodi?
  - KOLIM OL SAMTING Sampela blong dispela ol samting yu toktok long ol nau ya, igat sampela long ol em ibikpela moa long ol narapela? Blong wonem?
6. Long dispela hevi (KOLIM HEVI ONE AT A TIME), nau yu tok long em ya, igat sampela samting yu save wokim long stretim dispela hevi?
  - Sapos nogat, igat rot long stretim dispela hevi? Yu bai laikim sampla samting long stretim dispela hevi?



- Na long taim yu save painim sik o sampela kain bagarap long bodi yu save kisim helpim long we?
7. Taim yu gat hevi (KOLIM HEVI ONE AT A TIME) o sapos yu painim dispela kain hevi yu bai toktok wantaim husat stret? Blong wanem?
  8. Yu save go long hausik tu taim yu save painim sampela kain ol wari o hevi? Wonem kain hevi?
    - Yu bin pilim olsem women taim yu go long haus sik long stretim dispela hevi bilong yu?
  9. MENTION PROBLEMS THE WOMAN HAS TALKED ABOUT ONE AT A TIME I gat sampela lain isave givim ol gutpela tingting na helpim, dispela kain ol lain, yupela bai laikim sampela tingting o skul bai ol iken helpim yu tu?

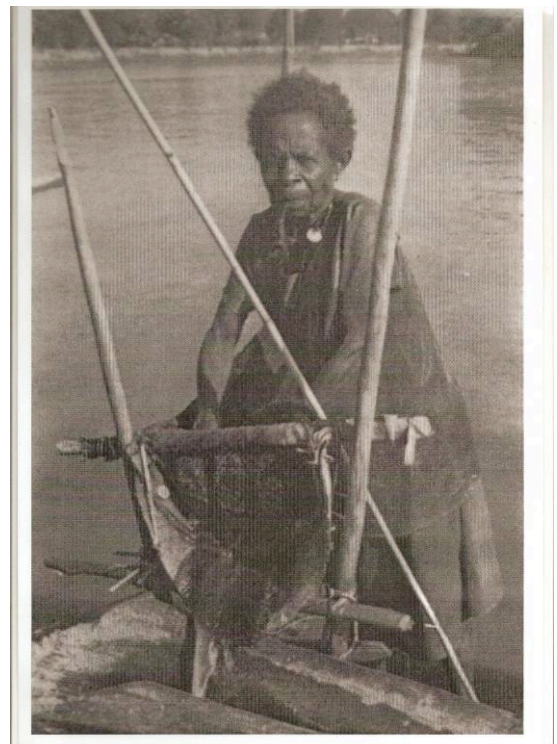
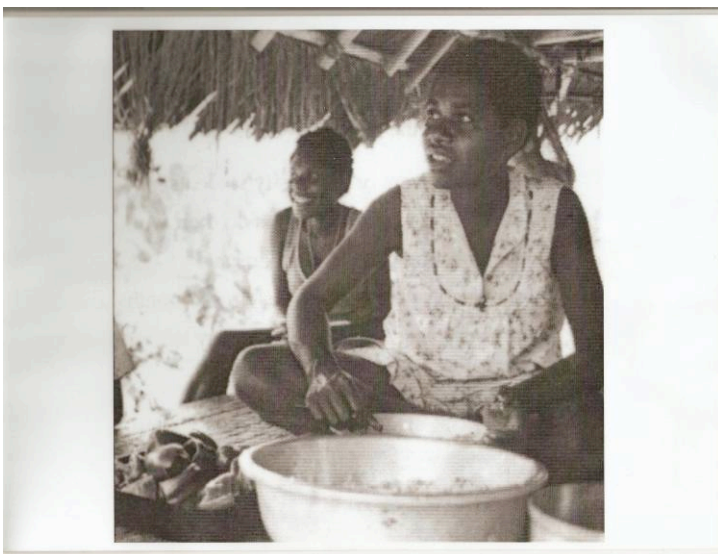
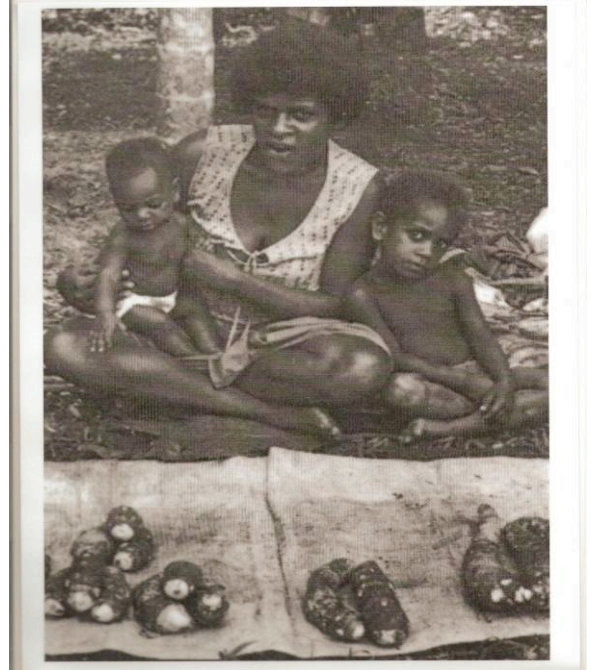
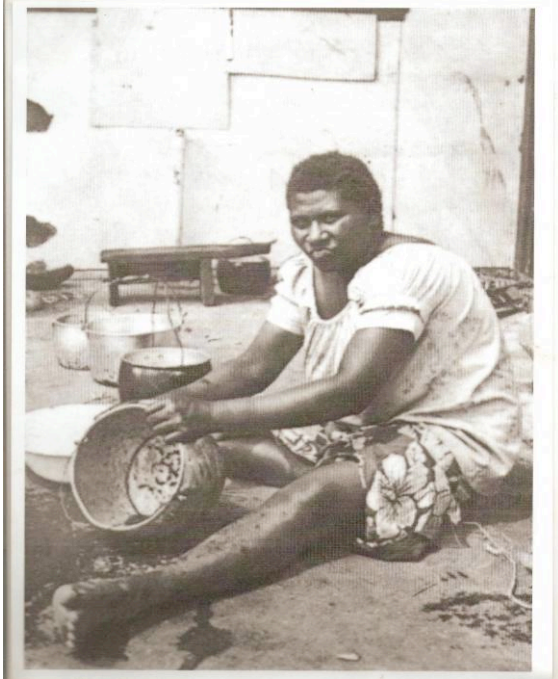
## **Appendix VII**

### **Photo narrative exercise discussion guide**

- Can you describe the photo – who is in it? What is she doing?
- Think of some of the girl's / women like her in your village. What might this girl's/ woman's life be like?
- What sort of (health) problems might she have?
- What do you suggest could be done to help her?
- What might her hopes for the future be? (pictures of young and adult women only)

## Appendix VIII

Example of photos shown as part of photo narrative exercise



## **Appendix IX**

### **Participatory diagramming exercise facilitation guide**

- What is a woman's life like here?
  
- What are the main health problems women face?
  - Participants represent problem with local item (i.e a sweet potato for workload).
  - Participants rank which problem is the worst, not as bad etc
  
- Establish criteria for the problems
  - Why is this problem the worst? How does this problem affect you
  - Why is this problem not so important?
  - How do these problems work together to affect your life?
  
- Which problems are within your control to change/improve and which are not? How do you try to deal with these problems?
  
- Who do you turn to for each of these problems?

## Appendix X

### PNG Medical Research Advisory Committee Ethical Clearance



GOVERNMENT OF PAPUA NEW GUINEA  
MEDICAL RESEARCH ADVISORY COMMITTEE  
Department of Health

Telephone: +675 301 3650  
+675 301 3660  
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PO Box 807  
Waigani, NCD 131  
Papua New Guinea

13<sup>th</sup> May 2005

Ms. Rachael Hinton  
PNGIMR  
Goroka

Dear Ms. Hinton,

This is to certify that the proposal:

**Defining women's health in PNG: implications for health service delivery**

Submitted by you and your colleagues has been examined by the Medical Research Advisory Committee of Papua New Guinea and assigned **MRAC No. 05/09**. The proposal was approved and given ethical clearance for it to be carried out in Papua New Guinea.

The Medical Research Advisory Committee of Papua New Guinea act as the National Ethical Clearance Committee and as the Institutional Ethical Committee for the Papua New Guinea Institute of Medical Research and so there is no further bar to this project being carried out in Papua New Guinea.

Investigators are reminded of the importance of keeping provincial health and research authorities informed about their study and its progress, and of submitting progress and outcome reports to the Medical Research Advisory Committee.

With best wishes

Yours sincerely

A handwritten signature in black ink, appearing to read 'Gilbert Hiawalyer', written over a horizontal line.

Dr Gilbert Hiawalyer  
Chairperson

Cc: Professor John Reeder  
PNGIMR, Goroka

## **Appendix XI**

### **Statement of information**

My name is Rachael Hinton and I am currently conducting research for the PNGIMR. We are undertaking this research because we would like to learn about the life of women here in the Wosera. In particular we would like to understand how young and adult women think about their health and how this may affect women's access to services. It would be very helpful if you could take some time to talk to me about some of the good things but also some of the problems women face here. We would also like to hear about what you see as your main health concerns, what you do to look after your health and the experiences you have had with health services. Your answers would help us to gain a better understanding of the barriers women face to achieving good health and to design a more effective way of meeting the health needs of women in the Wosera.

A number of women will be interviewed for this study. We would like to take about one or two hours to talk with you all as a group and ask some questions. There are no right or wrong answers. Your participation is voluntary so you can choose to withdraw from the discussion at anytime.

Of those of you who agree to participate we would like to tape our discussion and write down your answers. Your information will be kept confidential and will only be used for this study. It will be destroyed after five years. Your anonymity will be maintained and you will not be identifiable in any published material.,

The interview will be conducted in a language you feel most comfortable with. Some of the issues we discuss may be sensitive or private. We will also try as much as possible to keep people from hearing our discussion but I cannot guarantee this will be possible or that they will not tell others. By taking the time to talk with us, we may be keeping you from doing other things. But we do hope that this discussion will provide you with a chance to talk about issues that are important to you but which are sometimes ignored or forgotten.

Do you have any questions?

Thank you for your cooperation.

This project was approved by the PNG Medical Research Advisory Committee.

## Appendix XII

### Consent form

\_\_\_\_\_ has been provided with information about the research project, *Exploring the meaning of health for young and adult women in PNG*, developed by Rachael Hinton and her supervise and agrees to participate. The participant understands that the project is being conducted for the PNGIMR and for the degree of Doctor of International Health at Curtin University.

The participant has been informed of and understands the purpose of the study. They understand they can withdraw from the study at any time without prejudicing them in any way. They have been given the opportunity to ask questions.

They are aware that any information that might potentially identify them will not be used in published material and will not be used for any other purpose than defined in the objectives of the research.

\_\_\_\_\_ has verbally consented on tape to participate in the study as outlined to them.

Signed \_\_\_\_\_ (Principal Investigator) \_\_\_\_\_ (Date)

Signed \_\_\_\_\_ (Research Assistant) \_\_\_\_\_ (Date)

## **Appendix XIII**

### **Copy of statement of contribution by co-authors**

To whom it may concern,

I, Dr Jaya Earnest, contributed to the outline, provision of relevant references and the review of drafts, for publications undertaken with Rachael Hinton. These publications were entitled:

1. Beyond risk factors to lived experiences: Young women's experiences of health in Papua New Guinea
2. Assessing women's understandings of health in rural Papua New Guinea: Implications for health policy and practice
3. The right to health: overcoming inequalities and barriers to women's health in Papua New Guinea
4. "I worry so much I think it will kill me": Papua New Guinean women's accounts of their lives and their health problems
5. Coping, Stressors and Social Support among women in Papua New Guinea

.....  
Dr Jaya Earnest

.....  
Rachael Hinton