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Anne Knippa

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Understanding how poverty shapes lifestyle: a qualitative study of people living in Hedmark, Norway

Forstå hvordan fattigdom former livsstil: en kvalitativ studie av folk som bor i Hedmark, Norge

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Innhold

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Norsk sammendrag

Målet med studien: er å undersøke hvordan det å leve i fattigdom i en landlig del av Norge påvirker valgene som er tilgjengelige for mennesker, hvordan disse former livene de fører og hva som kan være konsekvensene av dette for helsen deres. Forskningen tar sikte på å belyse, hva som til daglig blir betegnet som "livsstil", helse og sosioøkonomisk status, påvirker hverandre, særlig i forhold til inntekt i Norge, som er en sosialdemokratisk velferdsstat.

Teori: denne studien bruker Cockerhams helse livsstils teori (health lifestyle theory), som fokuserer på sosiale praksiser for å konseptualisere (forklare) funnene. Ifølge Cockerham har livsstil flere roller når det kommer til helse, ved at den fungerer som et kollektivt eller sammensatte mønster av atferd som er normativ i bestemte settinger (tilfeller) for den enkelte. Cockerham understreker at helse livsstil ikke er ukoordinerte adferd av frakoblede (enkelt) individer, men personlige rutiner som går sammen i aggregater som representerer ulike grupper og klasser.

Metode: denne forskningen har et epistemologisk perspektiv med en interpretivistisk syn for å forstå hvordan folk gir mening til sin sosiale virkelighet. En kvalitativ tilnærming var derfor hensiktsmessig. Seks semi-strukturerte intervjuer med personer med lav inntekt i Hedmark ble gjennomført i 2017. Deltakerne var mellom 30 og 70 år gammel, og det var en mann og fem kvinner.

Funn: tre temaer ble utviklet som ble utviklet ut fra datamaterialet. Disse temaene er; - Helse som å vite og gjøre; - Følelse av isolasjon; - Finansielle bekymringer som livstids dom. Funnene i denne studien sett i lys av Cockerhams helse livsstils teori gir en forståelse for at mulighetene og valgene deltakerne (og andre i samme situasjon) har er begrenset for å leve et sunt og tilfredsstillende liv. De opplever vanskeligheter og de føler at det er få alternativer for å klare å endre livsstil. Fattigdom former og påvirker disse menneskenes helse fordi det begrenser dem på så mange måter, og de valgene de tar er ofte ikke det de egentlig vil, men de har ikke mulighet til å velge annerledes.

Konklusjon: hva denne studien kan legge til forskningslitteraturen er de klare og entydige funnene som at deltakerne føler seg isolert og fanget i ond sirkel. Funnene som gjelder den onde sirkelen gir også en bredere og mer detaljert forståelse av hvordan lav inntekt bidrar til å opprettholde den dårlige helsen ved måten deltakerne beskriver at de ikke klarer å gjøre endringer selv og at den fysiske helsen påvirker den psykiske helsen og motsatt. Forslag til hvordan forbedre folkehelsearbeidet er at mennesker som jobber med og møter mennesker med lav inntekt gir dem den hjelpen den enkelte har behov for, at de støtter og viser forståelse, har tid til å lytte og møter dem hvor de er.

Abstract

The aim: is to explore how living in poverty in a rural part of Norway influences the choices available to people, how these shape the lives they lead and what might be the implications of this for their health. The research aims to shed light on how, what is commonly termed 'lifestyle', health and socioeconomic status, particularly in relation to income, are interrelated in Norway, a social democratic welfare state

Theory: this research uses Cockerham's health lifestyle theory, that focuses on social practices to conceptualize the findings. According to Cockerham, lifestyle has multiple roles when it comes to health, in that it functions as a collective or shared pattern of behaviour that is normative in particular settings for the individual. Cockerham emphasises that health lifestyles are not uncoordinated behaviours of disconnected individuals, but personal routines that merge into aggregates representing different groups and classes.

Method: This research has an epistemological perspective with an interpretivist view in order to understand the way people make sense of their social reality. A qualitative approach was therefore appropriate. Six semi-structured interviews with people living on low income in Hedmark, Norway in 2017 were conducted. The participants were between 30 to 70 years old, and there was one man and five women.

Findings: Three themes were developed that were grounded in the data. The themes being; - Health as knowing and doing; - Feeling isolated; - Financial worries as a life sentence. The findings of this small-scale study viewed through Cockerhams health lifestyle theory give an understanding that the chances and choices the participants (and others in the same shoes) give limited opportunities for leading a healthy and fulfilling life. They experience hardship and they feel there are few options for real change. Poverty shapes and influence these peoples' health because it constrains them in many ways and the choices they make are often not what they actually want, but they are not able to choose differently.

Conclusion: What this study may add to the research literature is the clear and unambiguous findings that the participants feeling isolated and trapped in a vicious circle. The findings regarding the vicious circle also give a broader and more detailed understanding of how low income contributes to the poor health being maintained, in the way participants describe they do not manage to make changes by themselves and that the physical interact with mental health as well the other way round. The implications for public health work is that people who work in public health (or elsewhere) give people in these kinds of circumstances the help they need, such as support and understanding, time to listen and meet them where they are, and try to find out what are their individual needs.

1. Introduction

1.1 The purpose of this master thesis

The focus of the research outlined in this master thesis is on Norwegian people living in poverty. More specifically, the research aims to explore how living in poverty in a rural part of Norway influences the choices available to people, how these shapes the lives they lead and what might be the implications of this for their health. In this way, the research aims to shed light on how, what is commonly termed as 'lifestyle', health and socioeconomic status, particularly in relation to income, are interrelated in Norway, a social democratic welfare state. The researcher might also shed some light on how inequalities in health are maintained in such a country.

1.2 Defining and measuring poverty

Poverty is a universal concept, but its definition is often contested (Gordon, 2006). A key distinction is between ‘absolute’ and ʽrelative’ poverty. The World Bank (WB) uses the “one dollar a day” poverty line that was developed in the 1990’s, that now has become USD 1,90 a day (Islam, 2016). The WB estimates that around 700 million people live in poverty according to this definition. These numbers include people who live in extreme (absolute) poverty. Most of these people live in American, Asian and African countries (Islam, 2016; The World Bank, s.a.). Extreme poverty means that people cannot meet their basic needs, relating to food, clothing, housing, access to primary health care and basic education (Fløtten, Skog Hansen, Grødem, Grønningsæter & Nielsen, 2011). This type of poverty was more common historically in many developed countries, including Norway, but with the introduction of modern welfare states, is believed to no longer exist.

In 1984, the European Commission extended the definition of poverty to this:

> The poor shall be taken to mean persons, families and groups of persons whose resources (material, cultural and social) are so limited as to exclude them from the minimum acceptable way of life in the Member state in which they live (EEC, 1985, as quoted in Gordon, 2006, p.30).

This is an 'official' definition of (relative) poverty, which is used in the European Union for all 28 member states (Gordon, 2006, p. 30; Trondal, 2016). Many countries, including Norway use measurements of income when defining poverty, because it is easily comparable in both time and space, and because income is necessary in modern society to obtain benefits.

As Norman (2009) indicates, in contemporary society, the term 'relative poverty' is more commonly used to describe poverty in relation to the rest of the population of a country: those who are substantially worse off than other people and whose lives fall below the generally accepted living standard of a country (see Gordon, 2006 above). In Norway and Europe people are said to be living in relative income poverty (FN [is UN in Norwegian] 2016). The relative income poverty concept was developed by Townsend (Townsend, 1985). He argues that poverty is dynamic, not a static concept or an absolute state. By this he means that man is a social animal, entangled in a web of relationships which exert complex and changing pressures to which he must respond, in both his consumption of goods and services as in any other aspect of his life (Mack, 2016; Townsend, 2010). Townsend describes poverty as relative deprivation, where he argues that individuals and families whose resources fall seriously short of the resources commanded by the average individual or family in the community in which they live, whether it is local or national are in poverty (Townsend, 2010). He also argues that deprivation should be seen as social exclusion from ordinary patterns, customs and activities of society (Mack, 2016). By this he means that

people can be deprived if they lack the type of clothing, diet, housing, household facilities, fuel and environmental, working, education and social conditions, activities and facilities which are customary, or at least widely approved in the society which they belong to. It is this definition of poverty that is used in this master thesis. In the 60s and 70s, when the welfare states were developing, there was a common belief that poverty had been virtually eliminated in Britain. The cause of this was believed to be full employment, combined with larger real wages and the increase in numbers of women in payed work. There had also been a marked redistribution of income from rich to poor and a continuing equalization of income and wealth. There was as well the introduction of the welfare state that had created a net which prevents nearly all those who are sick, disabled, old or unemployed from falling below a civilized standard of living (subsistence) (Townsend, 2010).

Measures of relative poverty are also usually based on income. The Organization for economic and co-operative development (OECD) measures poverty by taking half (OECD50) the median household income of the total population. When using this estimate, there are around 5 billion people living in poverty, which is about 68% of the population in the world (Islam, 2016; OECD, 2016). This measurement includes poverty in rich countries as well as poor countries, because when talking about global poverty it is usually accepted that it is important to include all the poor in all countries (Islam, 2016).

In Norway, the EU60 – scale, (60% of median household income) is the most commonly used measurement tool for low income (Langeland, Dokken & Barstad, 2016). When using this measurement about 10-11 per cent of the Norwegian population live in relative poverty. Compared with other European countries such as England, this is low. (Fløtten, et al., 2011; Norgeshelsa, 2014; Refsgaard, 2008). Poverty is also a normative concept and many prefer to use the term “low income” to describe the situation of those who find themselves at the bottom of the income distribution (Fløtten, et.al., 2011).

1.3 Poverty in Norway

The Norwegian government has stated that it will work to make Norway a country with low levels of income disparity and minimal poverty (Political Platform, 2013). The vast majority of the Norwegian population has a high standard of living and good living conditions. Several international comparisons show that Norway is among the countries in the world with the smallest differences in living conditions. It is also a country with a well-developed and organized welfare system. High and stable economic growth over many years has resulted in significant real income for most people, but when looking at the development in a long-term perspective, it is evident that income differences are increasing (Langeland, et.al., 2016; Fløtten, et al., 2011) and alongside this differences in life expectancy and other health indicators (Folkehelserapporten, 2015).

There is a gender difference in poverty. Both globally and in Norway women are more likely than men to live in poverty. In Norway about two per cent more women than men live in poverty (Folkehelseinsituttet [FHI], 2015). Women are more often than men single parents, a group that has much higher rates of poverty than other groups in the population. For example, in 2007 nine per cent of women compared with four per cent of men had income under the poverty line. Contributing causes to this are that single mothers more often are unemployed and that women more often than men have low income jobs (Fløtten, et al., 2011), even in Norway where gender equality laws have been in existence since 1978. There has also been an increase in children living in families with low income in Norway, especially since 2000. In 2012, eight per cent of the children in Norway were living in households with low income, and in 2013 it had increased to 8,6 per cent (Epland & Kirkeberg, 2015). Also, elderly people living on minimum pension and immigrants, especially those who are not from a western country are in high risk of living in poverty (Føtten, et.al., 2011).

1.4 Poverty and health

The link between poverty and health is well documented. Rene Villermè compared mortality rates and poverty in Paris in the 1820s, and in 1851 after the first census in the United Kingdom a gradient of health in social classes defined by occupation was demonstrated. This was perhaps some of the first scientific evidence that economic deprivation was strongly related to ill health (Deaton, 2002). In Norway Eilert Sundt (1817 – 1875) was the first to systematically examine people's living conditions and everyday life. He was a pioneer of the sociological survey of peasant and working class living in Norway (Skirbekk, 2013). People who are poor, tend to be more sick and die at a younger age than people who are rich and this pattern follows a social gradient. Morbidity and mortality rates are strongly related to many correlates of socioeconomic status, such as income, wealth, social class or level of education and the gradient persists in recent data from a number of countries (Deaton, 2002) including Norway (Mackenbach, 2017).

When studying social groups, there are systematic differences in health which follows the pattern of a gradient. The higher the level of income or education a group has, the better health they experience. This is called social inequalities in health. There are significant differences in health and lifestyle in social groups in Norway. These inequalities are viewed by the government as unfair, and represent a loss for individuals, families and society (Folkehelserapporten, 2015). Therefore, reducing social inequalities in health has become a goal for Norwegian governments, including the most recent government stating this in recent policy documents (see St. meld.6 2002-2003, St. meld.20 2006-2007 and St. meld.34 2012-2013). Social inequalities in health are a public health problem because they reduce quality of life, life expectancy and wellbeing. Additionally, they manifest themselves by reducing life chances, social participation and self -sufficiency (among others), values highly appreciated in Norwegian culture (Dahl, 2002).

Low income is a risk factor for (ill) health, a fact documented in all western countries. Poor people have generally higher proportions of chronic diseases, such as heart and lung diseases, worse mental health and unhealthier lifestyles (FHI, 2015). An example is people living in lower socioeconomic groups including those living in poverty are more likely to smoke, and have higher levels of alcohol dependency compared with those in higher social groups or those who are not poor. At the same time, income can have an impact on the ability to acquire a healthy diet and on possibilities of using training facilities (Kverndokk, 2006; FHI, 2015).

There has been a dominance of individual behavioural approaches to public health and health promotion particularly in relation to trying to narrow inequalities in health . These focus on giving people information to improve their knowledge about healthy eating, the role of physical activity in health and the importance of moderate alcohol consumption, for example. They also tend to assume that people who do not meet the recommendations with regard to these things are not motivated to change and therefore efforts to improve their motivation (for example through motivational interviewing) are advocated. In addition, the Ottawa Charter talked about making the healthy choices the easy choice but this has mainly been interpreted in health promotion policy and practice through a focus on trying to change individuals, what Baum has called 'lifestyle drift' (Baum, 2011; Veenstra & Burnett, 2014), rather than changing the environment to enable healthy choices to be made, especially among those at the lowest part of the health gradient. Such individual 'lifestyles' approaches are based on the idea that all individuals (regardless of social position) are responsible for their health and choices they make. This research tries to understand how living in poverty and thus on low income in Norway might shape health related choices in particular ways.

Poverty is often seen in big cities and capitals, in both Europe and Norway (Statistisk sentralbyrå [SSB], 2005). However, in Norway, only half of the population live in

cities/towns with a population over 8000 people. This research project will be carried out in the county of Hedmark, situated in the eastern part of Norway. This county has a relatively high proportion of people with low levels of education and income compared to the rest of the country. For example, in 2015 only 76,6 per cent of the population in Hedmark had completed higher education. This is below the average for the whole country, which was 81, 5 per cent (Refsgaard, 2008; Norgeshelsa statestikkbank, s.a.).

1.5 Understanding how poverty generates health-related social practices

In contemporary society, the pursuit of health has become one of the more salient practices where personal responsibility for health is considered a requirement for individual autonomy and good citizenship (Crawford, 2006). However, this master thesis will look at health and lifestyle from a sociological perspective. This means that both health and lifestyle are constructed in relation to social structures, experiences and systematically articulated with other meanings and practices (Crawford, 2006). Cockerham (2005) has said that many daily lifestyle practices involve consideration of health outcome, and when talking about lifestyle people tend to think that it is a matter of individual choices. However, lifestyle has its theoretical origins from Weber, from the early twentieth century, his focus was on the way people act in concert, not individually. Weber also emphasised how social institutions and widespread belief systems (capitalism) were powerful forces in shaping the thoughts and behaviour of individuals. This master thesis views lifestyle not as an individual responsibility but as a social practice, which is coherent with its original meaning.

Further this master thesis will focus on those living in relative poverty, since this is the type of poverty identified in Norway. The terms used in this master thesis will be poverty and low income, since these are the words most commonly used in the literature in both research and political documents, rather than the term deprivation since it is not commonly

used in Norway or in Norwegian literature. However, in this research Townsend's concept of deprivation is used when talking about relative poverty and is operationalized in the research. However, as discussed above, poverty is seen as multidimensional, that is to say, not just in financial terms but in relation to the totality of resources, and as having a diverse number of consequences, especially in relation to health and lifestyle.

1.6 Research question

The focus of this master thesis is on Norwegian people living in poverty. The research seeks to get an understanding of how people in Hedmark with low income live their lives, understand how their choices are made and what might be the implications of this for their health. This should lead to knowledge of lived experiences that can contribute to a better understanding and help for these people. Given the evidence that health and income are interrelated and that the choices one has available can have implications for social practice (lifestyle) the question that will be explored in this research project is: "How does living in poverty in Hedmark, Norway, shape people's everyday choices related to health"?

2. Literature review: poverty and health

2.1 Introduction

The purpose of this chapter is that to present the literature reviewed of the existing and relevant research on the subject. In the following, some international research is introduced, that will give insight to the knowledge on the subject. This will also give a broader and better understanding of how this research is conceptualised. A lot of the research has come from England, where it was driven by an interest in understanding health inequalities, and how in particular, living at the bottom end of the social scale influences health and lifestyle. Then some of the Norwegian research of the theme is presented. In the end the gap is presented and gives arguments for why this research project was conducted.

2.2 International research on poverty and health

There are gross inequalities in health between countries and within countries. For instance, life expectancy at birth in Sierra Leone is 50,1 years, compared to Japan, where it is 83,7 years. In the USA, there is a 20-year gap in life expectancy between the most and least advantaged populations. One response to these health inequalities is to put more effort into the control of major diseases and to improve health systems. A second is to deal with poverty (Marmot, 2005; World Health Organization [WHO], 2015).

One can also see social inequalities in health within high income countries, not only in the USA but also in England and other European countries. Even though the health status for the overall population in a country improves, the disparity in health status among the low social groups is not disappearing (Marmot, 1994). In Norway, there are also social inequalities in health, and it is easily seen in measurement of life expectancy. For example,

comparing life expectancy in Oslo, one can see that men living in the west part of Oslo can anticipate living 8,8 years longer than men living in the east part of Oslo (SSB, 2013).

Mackenbach (2017) has given explanations for why those at the bottom of the social gradient with lowest social position, that is to say, those living on a low income or in poverty have the poorest health. He states that it is an heterogenous mix of factors that includes the persistence of material inequality at a lower, but still a substantial level, the increasing importance of consumption behaviour and non-material resources for population health and the increasing importance of health-related selection during social mobility, and the fact that resources are unequally distributed over social positions.

The dominant way of viewing this until relatively recently has been in terms of individual responsibility for personal health behavior, with people often being blamed (victim blaming) for lacking knowledge and or motivation to develop healthy lifestyles. This shows how psychological perspectives have tended to dominate these discussions in public health. More recently sociological perspectives have questioned this perspective by trying to understand the development of 'social practices' in relation to a person's social situation (or social position). In the following, there will be a review of research that has focused on understanding health actions in relation to social position in order to shed light on how living in difficult social circumstances shapes social practices.

2.3 From health behaviour to social practices

Hilary Graham has written extensively about social inequalities in health and health related practices, which are key themes in much of her work. In particular, she has researched how living on a low income as a woman (using the concept of social position) shapes health practices, where she has written several articles about women and smoking. One article from 1989, is two folded, where the first part is about the historical journey of

women's smoking pattern in the UK. The second part is mix-method, where the quantitative data is derived from national studies, that provides statistical information on household, income and expenditure. The qualitative part seeks to locate women's smoking behaviour within the material and social conditions in which they cared for children. This research shows that low income households spend relatively less than other households on nonessentials items, such as clothing, footwear, transport, household goods and services. The exception is tobacco. Low income households spend relatively more on tobacco compared to other households particularly among households with children, where adult needs are denied in the struggle to make ends meet. The study found that smoking was associated with breaks from care (for children), and it was also a way for these women to cope with breakdowns. The women also said it was the one thing they did for themselves (self-directed activity) and spent money on themselves, even though they were aware of the health risk of smoking. The article concluded that women tend to develop coping strategies, such as smoking to get them through difficult everyday circumstances related to their social position. The article explained that in the situation of domestic pressure and shortage of material and social resources, family welfare may be prioritized at the expense of individual health. Graham suggests that smoking is a part of an individual response to disadvantage, that it functions like a complex array of coping strategies that maintain the fragile balance of everyday life (Graham, 1989).

More recent work by Graham (1999), was on patterns and predictors of cigarette consumption among women. This is a quantitative study and is based on the British Household Panel Survey (BHPS) from 1991. There were 920 female smokers in the age of 16-49 that were included in the study. The study looked at the influence of three key factors: socioeconomic circumstances, psychological health and partners smoking status. The results from the study showed that there was a strong socioeconomic gradient in consumptions in all

measures of socioeconomic status, education, occupation, school leaving age and degree of crowding. Psychological heath showed also a significant association with consumption, where those with poorer health were smoking more cigarettes a day. Age was also found to be significantly related to consumption in this study. The lowest level of consumptions was among woman in the 16-24 age group. There were two broad conclusions drawn from this study, the first was that because of the steep socioeconomic gradient in tobacco use and the dose-response relationship between tobacco intake and disease risk, the risk of smoking related diseases is higher among disadvantaged smokers than more affluent smokers. The second conclusion drawn from this study was that psychological health was the single most powerful predictor of high rates consumption of cigarettes (of the factors tested in the analysis) (Graham, 1999).

The findings above indicates that the health and the risk of ill health of people with low income is greater than compared with the more affluent population. It also supports Graham's earlier research in that smoking develops as a social practice among those living in disadvantageous circumstance, particularly for those with poorer psychological health. In the next research to be presented the researchers have looked at the perception and practice of people living in poverty regarding health.

The study of Macintyre, McKay and Ellaway (2004) looked at lay perceptions of health inequalities by people from differing social classes and neighbourhoods in Glasgow, Scotland. They used data from The West of Scotland Twenty 07 Study: Health in the community, which is a cohort study. There were two socially contrasting areas of Glasgow city involved. One was socio-residentially advantaged and had better health indices, the second was socio- residentially disadvantaged and had worse health indices. But neither was at the extreme of health or social advantage/disadvantage. The achieved sample seize was 658 (355 in the advantaged and 303 in the disadvantaged group), and the participants was

divided in to the following age groups: - 25, - 45 and 65 years old. They were asked a direct question, “who do you think is more likely to have the following experiences: heart disease, being fit, cancer, mental illness, accident/injuries, living longer; rich people, poor people or both about the same?” (p. 314). They used a quantitative multivariate approach to analyse the data. In summary, the overall most common response from the respondents was that for most conditions, both rich and poor were equally likely to experience them. There was a statistically significant difference between social classes in the perception of whether rich or poor people were more likely to be fitter and liv longer. There was also a small difference between social classes, where poor people were less likely to think that poor people have worse health than the rich (Macintyre, McKay & Ellaway, 2004).

In 1997, Blaxter explored peoples own conceptions of the reasons for health inequalities. Blaxter did a two-sided paper, were she first looked at some large-scale survey evidence, then reviewed the extensive body of qualitative and biographical research on attitudes to health. Blaxter looked at the British Health and Lifestyle Surveys from 1986-7 and 1991- 2. These surveys have large nationally representative samples with lot of data that can give information about individuals’ health, health related behaviour and life circumstances. In the summary of this survey, Blaxter concluded that all social groups emphasise “healthy” behaviour, and she notes that self-responsible lessons of health promotion appear to be widely accepted. That is to say, that even those at the lowest end of the social scale think they take responsibility for their own health. Furthermore, it is the more advantaged people – those at the higher end of the social scale - who appeared to be aware of how structural factors, such as income, work and environment influence health. Some qualitative studies of lay views suggest that health and illness are not simple concepts, and that each must be distinguished, because health is not perceived as the opposite of

illness. It is also commonly found that people prefer to claim health, if possible (Blaxter, 1997).

The clearest findings from Blaxter's work using data from the health and lifestyle survey is that respondents tend to neglect structural causes of health and illness. This may be the explanation why in qualitative studies lay people rarely talk about inequalities. Because talking about inequalities can give feelings of disbelief and unease, especially among those most at risk. Blaxter notes that there can never be a perfect correlation between illness and social or economic circumstances when recognising the complexity of the causes of ill health (Blaxter, 1997).

The qualitative literature was full of notions of self-responsibility and self-control where illness tends to be viewed as one's own fault, not simply through a carelessly unhealthy lifestyle, but also because of character failings or weakness of will when coming to healthy practices. Blaxter also concludes that to acknowledge inequality would be to admit an inferior moral status for oneself or one's peers. Internalised values of self-control emerge for everyone, perhaps particularly for those who cannot claim lifestyles which are actively health promoting. The view of inequality in health is a "threshold" on levels of disadvantage, in that below the threshold health would be affected and above it peoples' chances would be more or less equal, rather than the regular gradient throughout the social classes. When considering the moral imperative in Western society to be healthy, it is understandable that those who are most exposed to unequal health will be least likely to talk readily about their risk status (Blaxter, 1997).

Crawford (2006) also talks about this individual and moral responsibility for health and he said that in modern society, there is an increasingly "healthiest" culture, where health behaviour has become a moral duty and illness has become a moral failing. This is seen in

several studies (especially in working class groups), were there is discussion of health as a moral identity (Crawford, 2006; Blaxter, 1997; Hervik and Thurston, 2016).

Wilkinson and Pickett carried out a review on income inequality and population health where they identified 168 analyses in 158 papers that reported on findings on the association between income distribution and population health. They classified these papers according to how far their findings supported the hypothesis that greater income differences are associated with lower standards of population health. Even though a large body of research suggest that income inequality in a society is a determinant of population health, it is still regarded as a controversial issue. Wilkinson and Picket found through their analyses that the relationship between income inequality and health is that income distribution relates to health, where it serves as a measure of the scale of social class differences in a society. The fact that social stratification is a fundamental feature of social organisation, explains why there are so many socioeconomic factors correlated to inequality (Wilkinson & Picket, 2006). This article is relevant to the topic of this dissertation because income inequalities are widening in Norway, and therefore a bigger part of the population is influenced by these circumstances. However, the specific issue that is of relevance to this dissertation is how being in a low social position in a country such as Norway where there is an expanded welfare state that looks after all to a minimum level from “cradle to grave” might shape the experience of living in poverty in relation to the emergence of social practices that are related to health. Hervik and Thurston (2016) found that Norwegian men from a variety of social positions living in Hedmark county both expected the Norwegian state to look after them whenever they needed it, as well as believing that they should also take responsibility for their health through being physically active, not smoking and so on.

Calnan and Williams (1991) conducted a small-scale study where they explored variations in health-related practices between households living in contrasting social and

economic circumstances. It was a qualitative study based on semi-structured interviews. There were 20 households, divided in two groups (10 households in each group), living in different socioeconomic circumstances. Both partners in each household were interviewed. The study showed that regardless of social and economic circumstances, matters of health seldom surfaced in people's description of their everyday lives. There was no concern with health in the context of behaviour either. Only when the interviewer probed, discussions of health matters emerged. Even so, most people in the study, regardless of socio-economic status believed there was an association between behaviour and health. The study highlighted the degree of differences that exists between the link, between health and behaviour. One link found was to fully understand the advice from medical professionals and health education campaigns which were the main ways of trying to promote health used in England at that time. Another link found was the private or informal realm of individual actions, that needs to be understood within a broader social economic and cultural context which is the focus of this dissertation.

Pampel, Krueger and Denney (2010), reviewed broad literature within economics, public health and sociology. The aim of the study was to classify explanations for lower exercise, poorer diet, excess weight and higher smoking among low socioeconomic status groups in a social perspective. With lack of clear support from the findings, they suggested to design studies that better test for the importance of the varied mechanisms to these unhealthy practices. However, Pampel et al. (2010) concluded that socioeconomic status can affect the motivation or incentive for healthy behaviour as it can affect the resources to reach the goals, and that each behaviour has several dimensions, such as time and effort required and its social meaning.

2.4 Norwegian research (on poverty)

After many years of research, it has become fairly well established in the public health arena that health, income and lifestyle are inter-related. Internationally, and especially in the UK a lot of research on poverty has been carried out in order to understand more fully these relationships. In Norway, the research is mainly quantitative. For example, Fagbevelgelsens senter for forskning, utredning og dokumentasjon (Fafo) is a Norwegian research foundation that contribute to both national and international research on poverty. Fafo has, for example carried out research concerning poverty scope and development in different countries, how poverty risk is distributed in the population, the consequences poverty can have and what are the causes of poverty. When Underlid carried out his research project he also stated there is little qualitative research on poverty in Norway. It will therefore be important to contribute, even though it is a small contribution to qualitative research in Norway.

In Norway, there were beliefs that poverty did not exist, and the Norwegian prime minister Oddvar Nordli stated in 1979 that: “It is for the first time in this country's history, and also for the other Nordic countries, we can say with certainty that poverty and social deprivation have become extinct” (Stjernø, 1985, p.13, quotation from Nestor, 1982, own translation).

This quotation from the (then) Norwegian prime-minister gave the impression that a goal in the establishment of the welfare state was achieved. A fair degree of financial safety was achieved for everyone in the population. Concerns for food, clothing and other forms of social and material goods were no longer a part of people's everyday lives. The strong and consistent economic growth in the post-war period had created greater material wealth among income earners. It was widely thought that the gradual expansion of the welfare state had led to a society where those who could not support themselves got their material needs

provided for by the social security system, so that poverty and social deprivation no longer existed. It is likely that this was the view for most of the population (Stjernø, 1985).

In the 1950s it became a growing and popular perception that poverty was either extinct or about to become so in the rich, capitalist and industrialized countries. However, during the 1960s was poverty re-emerged as a topic of discussion in many high-income countries after the United States revealed social problems in 1962. In the United Kingdom, Towsend (1979) revealed what financial problems some groups in the population had, and Sweden asked the question whether poverty really was eradicated in the late 1960s. Norway, however, differs from this development. Until almost mid-1980s the poverty concept has almost been totally absent from both public awareness and social policy research (Stjernø, 1985).

Stjernø (1985) described that modern poverty differs from the old one primarily because it is hidden. When wealth and over flow of goods are obvious to all, poverty becomes almost invisible. The poor are isolated from each other, and they are not visible to us others. External “facades” like housing and clothing are often not the things that reminds the poor of the financial difficulties they face every day, but the hardship of shortage that creates pressure, stresses and strains in everyday life, that other are struggling to see.

Stjernøs book is based on material from Norwegian statistics (SSB), derived from the living condition survey from 1973 and 1980, and interview material from Norsk opinionsinstitutt from 1983-4, as well as including other material.

Underlid has written about some of the psychological difficulties and hardship of living in poverty, which is discussed here.

In October 1999 to April 2000 Underlid conducted 25 qualitative interviews with people living in poverty in Norway. The purpose of his study was to explore the subjective

life-worlds of the poor, and the subjective meaning of relative poverty experienced day-by-day in an affluent welfare state by the poor themselves. The sample in his study was both men and women, living in the same Norwegian city, between 20 to 67 years old and all receiving social security payments. One important factor for Underlid's work is the lack of knowledge regarding qualitative research on poverty in Norway. Even though the work of Underlid has a psychological perspective many of his findings and views can help to better understand people living in poverty in this research project. Underlid has (among others) looked at how poverty gives rise to a sense of insecurity, social devaluation and the experience of inhibition or loss of autonomy (Underlid, 2005a-b, 2012). The research described in this master thesis is informed by Underlid's research and takes it further by exploring specifically how health-related practices (so-called lifestyles or behaviours in much of the literature in this field) are shaped by these feelings of insecurity, social devaluation and loss of autonomy.

2.5 The gap that this research aims to address

It is well established that there are inequalities in health between socioeconomic groups both between countries and within countries, also in Norway. It is also well known that living in poverty influences health in a negative way.

Even though there is extensive research on poverty this tends to mainly be quantitative and has in particular focused on individual responsibility and individual risk factors. This research is informed by a sociological perspective, in that it views people as social actors in a social world and therefore is people influenced by their social surroundings. What we do not know much about is how low income and poverty shapes people's lives and how this is reflected on health from this perspective in a social democratic welfare state such as Norway.

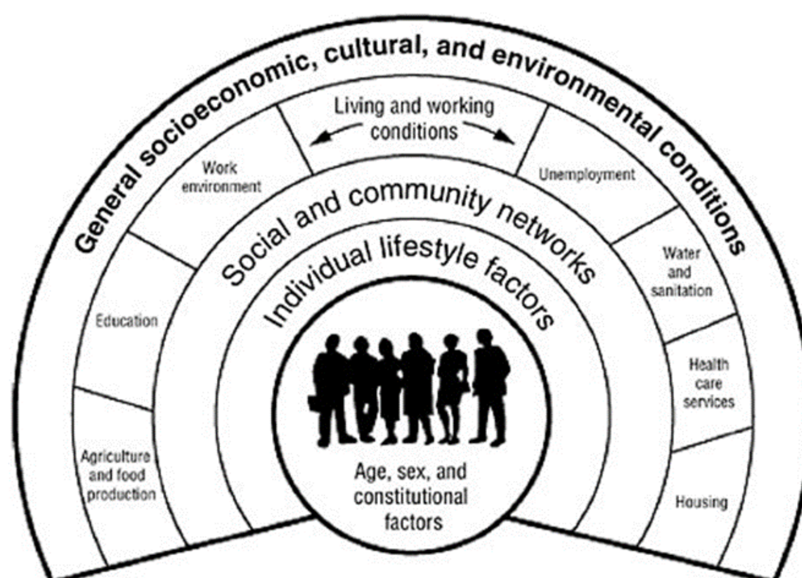
3. Theoretical orientation to the research problem

3.1 Social determinants of population health

Research over several decades indicates that the conditions into which people are born, where they grow up, and where they live their adult lives have a powerful influence on how healthy they are and how long they live, and as stated before there is a social gradient in health and wellbeing (Marmot, 2010). A person's social position influences the degree of exposure to health risks such as poverty, nutritional deficiency, dangerous working conditions, health damaging behaviours, degree of powerlessness and so on (Bird & Whitehead, 2012). These factors are often called the determinants of health (or root causes) that contribute to social inequalities in health. This social (determinants) model was proposed by Dahlgren and Whitehead (1993, cited in Bird & Whitehead, 2012) who conceptualized the determinants of population health in rainbow-like layers of influence in a figure (see Table 3.1), which they have called the social determinants of health. A persons, age, sex and other constitutional factors that influences health, but are largely fixed are placed in the core of the figure. The surrounding layers of factors that influence health is generally viewed as being ones that can – at least in theory - be modified by policy or practice. This model emphasises interaction between layers and between factors within layers. Lifestyles – that focus of this research – within this model are rooted in social networks and communities, living and working conditions, which in turn are related to the wider socioeconomic and cultural environment (Bird & Whitehead, 2012). The research problem is therefore conceptualized within this understanding of 'lifestyles' rather than the more common individually and personal oriented conceptualization based on a psychological model of health behaviour.

Cockerham's health lifestyle theory (2005), also looks at lifestyles as socially bounded and/or influenced, and shares the same view that there is interaction between and within factors that influences health. Cockerham's work focuses on social practices in particular. This body of work takes as its starting point the limitations of an individually oriented model such as the biomedical model. Other researchers (see for example, Chon, 2014) working from a social sciences perspective have also in recent years critiqued this model as not adequately explaining how lifestyles are developing in particular social contexts.

Table 3.1 The social determinants of health



3.2 "The Social Causation of Health and Disease: why income matters"

Stjernø (1985) describes that money is the universal measure of value in a capitalist society and is widely viewed as an expression of success in the labour market which can be converted into success in the housing market. Money gives people options on how a person can present him or herself in everyday life through clothes and appearance. Money creates the framework where a person can act – restaurant, concert and vacation, and has influence

on the contact forms in social life, the extent to which one asks guests home, visits others or meet others in public places. Stjernø (1985) stated that given that money has such a central place in the lives of most people, it is strange that social scientists have not been more concerned with what it means to have or not have money (Stjernø, 1985), which may be even more relevant in today's society.

Poverty, low socioeconomic status, unhealthy lifestyles, unpleasant work and living conditions and stress are among the many characteristic social variables typically regarded by lay persons as causes of ill health. Usually social variables are characterized as distant or secondary influences on health and illness. For instance, being poor is held to produce greater exposer to something that will make a person sick rather than bring on sickness itself. However, social variables may be more powerful in bringing hardship or enrichment in health outcomes than formerly assumed. Society may make you sick, or promote your health (Cockerham, 2013).

It is well established that most diseases have social connections. In public health, this idea is most obviously illustrated in the Dahlgren and Whitehead (1993, se Bird & Whitehead, 2012 above) model of the social determinants of health. This illustrates how the social context can shape the risk of exposure, the susceptibility of the host, the diseases course and outcome, regardless of whether the disease is genetic, metabolic, infectious, degenerative or malignant. Social factors can determine, not only whether or not a person becomes sick, but also shape the pattern of a population's health and disease, as well as how people experience illness (Cockerham, 2013). As Graham (2007) has pointed out, this is because these social factors are unequally distributed in the population according to people's social position.

Poverty is more than not having money but since money is the exchange agent that can be exchanged into almost all goods in society, lack of money will influence almost

all other aspects of life. Poverty has many dimensions such as housing, health, well-being and everyday life. Lack of money deprives people for the possibility to master their own lives by limiting the options they have available to them. In this situation people, Stjernø argues, become subject to external forces and structures that are not easy to act against. He views this as poverty being never able to choose. The tight way of life and constantly having to deny themselves the tangible benefits and the social and cultural life one wants to join can cause both psychological and physical health problems. It is especially true when it seems as if there is no way out of the economic scarcity (Stjernø, 1985). This is also in conjunction with what Townsend (1987) describes when talking about poverty when he describes that people cannot afford the diet they would like, participate in activities and enjoy other goods that is common in the society. In recent times this is described as people being 'socially excluded'.

Since the concept of a determinant requires a mechanism for action, finding social mechanisms at the collective level that affect health and disease at the individual level is a necessary element of evidence that social factors are causal. Locating such mechanisms one can use the traditional epidemiological triad of agent, host and environment. The relevance to the research carried out on this master project is to focus on the different influences that social factors can have on the agent – host – environment triad. Agents can be social, as seen in the health effect generated by lifestyle, occupation, class position, and neighbourhoods; people reflect traits that are both social (lifestyle, habits, norms and customs) and biological (sex, age, degree of immunity or other physical attributes that promotes susceptibility or resistance). Features of the environment are not only physical but social with respect to poverty and unhealthy living conditions, as well as social relationships, values, norms and forms of interaction in particular social contexts. Health related lifestyles are of relevance as a social mechanism producing negative or positive health outcomes. Everyone has a lifestyle

that is practiced on a daily basis, even the poor, and to ignore such a central form of behaviour (practice) weakens our ability to fully understand social behaviour (Cockerham, 2013; 2010).

Vallgårda (2011) also talks about lifestyle and she argues that the concept of lifestyle contributes to a strong focus on people's behaviour. She argues that the concept of lifestyle and especially lifestyle diseases generates incomplete ideas about the reason for ill health (or disease) and cause of death. She explains this by stating that behaviour – lifestyle, are not the only cause for disease (or ill health), the reason for that is that most diseases have multiple causes, explaining that people have different genetic predispositions for diseases. Factors early in life (even before birth) influences health in later life. There is also many other factors than behaviour (practices) in adult life which may increase the risk of getting these so called lifestyle diseases. For example, psychological and stress aspects, poor social network, unemployment, unsafe or polluted environment and so on.

According to Cockerham and others (se for example Williams, 1995), lifestyle has multiple roles when it comes to health, in that it functions as a collective or shared pattern of behaviour (agent) that is normative in particular settings (environment) for the individual (host). Health lifestyles can be decisive in determining an individual's health and longevity (Cockerham, 2013). In addition to stratification variables such as sex, race, and class, stressful life events and stress-process variables like social support qualify as social factors. This also includes a sense of control over one's life. People with control typically feel good about themselves, cope with stress better and have the ability and living situation to adopt healthy lifestyles. This (may) especially apply to people in powerful social positions, which allows them to feel in control, giving them a feeling of security and well-being that is health promoting. However, people at the bottom of society – for example, those living on a low income or in poverty are less able to control their lives and have fewer options from which to

choose. They have fewer resources to cope with stress, live in more unhealthy circumstances and face powerful constraints in adopting healthy ways of life and die younger (Cockerham, 2013). How these circumstances play out in Norway for those living in poverty is the focus of this thesis.

3.3 Health lifestyles theory

According to Cockerham (2010) the primary mechanism by which health is manufactured or weakened in contemporary society is through health-related lifestyles. Most people are born healthy, but living conditions and lifestyle practices *associated with these conditions* impact on their prospect for a healthy life throughout their life course. Cockerham (2010) defines health lifestyles as “collective patterns of health-related behaviour based on choices from options available to people according to their life chances” (p.159).

The health lifestyles theory is strongly influenced by the work of Weber (1864 – 1920) and Bourdieu (1930 – 2002). The definition above is influenced by Weber’s lifestyle concept, and it incorporates the dialectical relationship between life choices and chances. This means that health lifestyle choices are voluntary, but life chances either empower or constraints choices, as choices and chances work off each other in tandem to determine behaviour outcomes. Life choices are also a proxy for the use of agency and life chances are a form of structure (Cockerham, 2010) that is similar to Graham’s (2007) concept of social position. Social position (as reflected in a person’s gender, class, level of education and so on) influences life chances and therefore the choices that are realistically possible for a person in that position.

The theoretical conceptualization of health lifestyle is influenced by the agency and structure debate. Agency can be considered as a process where individuals recall their past, imagine their future, critically evaluate their present circumstances, and choose their

behaviour based on their (rational) assessment of the situation. Structure can be seen as sets of mutually sustaining schemas (plans) and resources that empower or constrain social action, and tend to be reproduced by that social action. Schemes are seen as compatible rules or procedures applied to the enactment of social life. Resources are either human (knowledge, strength, etc.), or non-human (manufactured or naturally occurring). This can be used to maintain or enhance power. Agency allows people to reject or modify their patterns, while structure limits the options that are available and shape the decision making (Cockerham, 2010). Over time such patterns tend to become established and increasingly resistant to change.

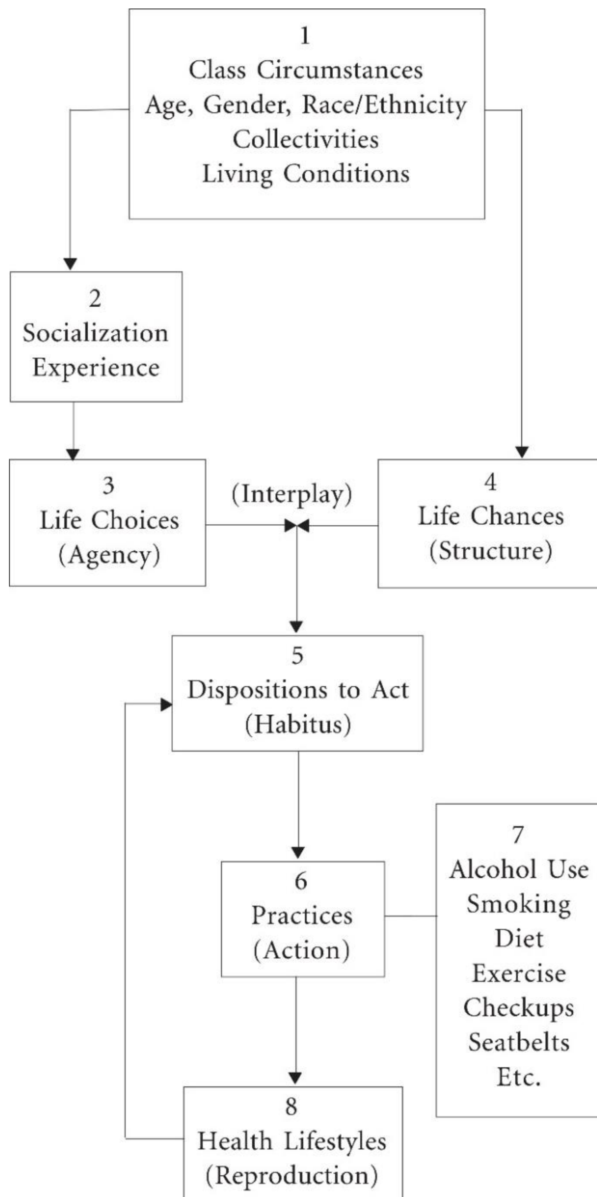
3.3.1 The health lifestyles model

According to Cockerham (2010) Weber associated lifestyles with status groups, in that way treating them as collective social phenomenon. By this he means that status groups are aggregates of people with similar status and class background, and they originate through a sharing of similar lifestyles. Bourdieu's work was also important in the development of the health lifestyle theory. Some of the common dimensions are how they understand practices, that are located in time and space, agency, structure, and habitus, that Cockerham has named "disposition to act" (Williams, 1995), and they both believe that choices are influenced by social settings.

It appears that – according to this model - health lifestyles are not uncoordinated behaviours of disconnected individuals, but personal routines that merge into aggregates representing different groups and classes. Table 3.3.1 illustrates the model of health lifestyle, where the arrows between the boxes indicate hypothetical causal relationships. In box 1, four categories of structural variables are listed, each having the capacity to shape health

lifestyles (Cockerham, 2010). In order to make sense of the model a short explanation of each box is given below.

Table 3.3.1 Health lifestyle model.



Box - 1: Class circumstances, age, gender, race/ethnicity, collectivities, living conditions. The first category of structural variables is class circumstances, which Weber gave the most insightful account for because of the close connection between class and lifestyles. Not only did he distinguish between status groups, he also observed the difference in particular ways of living and that people are social carriers of class-specific norms, values,

religious ethics and ways of life across generations. The one who gave the most detailed study of differences between classes was Bourdieu (1984), in his book *Distinctions*. Here he described (documented) differences in sports preferences and eating habits between the French upper-middle class and working class. Bourdieu noted that the working class met barriers not only economic, but also social, in the form of hidden entry requirements of family traditions, obligatory dress and behaviour, and early socialization (Cockerham, 2010; 2013).

Age, gender, and race/ethnicity: contemporary empirical studies have shown that these variables influence health lifestyles. Age affects health lifestyles because people often try to take better care of their health when they grow older. They do so by eating more healthily, by resting and relaxing more and reducing or abstaining from alcohol use and cigarettes. Gender is significant in that women tend to eat healthier food, drink less alcohol, smoke less, visit the doctor more often, wear seatbelts more often, overall have healthier lifestyles, (except for exercise). Young men tend to adopt the lifestyle of their father and young women their mothers. This sets the parameters for transmission of gender-specific health practices. Gender is a strong predictor of health lifestyle practices but it is moderated by class, because people on the upper strata eat more healthily, smoke less and exercise more, regardless of gender. Race and ethnicity are presumed to be important, but there is little research on this subject (Cockerham 2010; 2013).

Collectivities; are collections of actors linked together through social relationships, for instance work, religion, politics and kinship. They share norms, values, ideals and social perspectives that constitute intersubjective “thought communities” beyond individual subjectivity that reflect a collective world view. People may accept, reject or ignore normative guidance, collective views are nevertheless likely to be considered when choosing a course of action. Concepts of collective entities have meaning in the minds of individuals,

partly as something existing and partly as something with normative authority (Cockerham, 2010; 2013).

Living conditions: are a structural variable pertaining to differences in the quality of housing and access to basic utilities, neighbourhood facilities and personal safety. There is little research linking living conditions to health lifestyle, but the connection is important, because living conditions can constrain or enhance health lifestyles (Cockerham, 2010; 2013).

Box - 2 Socialization and experience: classic circumstances and the other structural variables in box 1, provides the social context for socialization and experience as the arrow shows. This means the disposition to act in particular ways are constructed through socialization and experience, where class position provides the social context for this process. It is through socialization and experience that a person (or actor) acquires reflexive awareness and the capacity to make choices (agency), while experience – with respect to life choices – provides the basis for choices (agency) practical and evaluative dimensions to evolve over time (Cockerham, 2010; 2013).

Box 3 - Life choices (agency): socialization and experience provide the capacity for life choices (agency). This word was introduced by Weber, as one of two most important components of lifestyles and refers to the self-direction of one's behaviour or actions. Life choices are a process of agency (choices), which individuals critically evaluate and choose their course of action. Individuals have the capacity to interpret their situation, make deliberate choices and attach subjective meanings to their action. This means that all social action takes place in a context with both constraints and opportunities, and the actor's (person) interpretive understanding of the situation guides behaviour choices (Chockerham 2010; 2013)

Box - 4 Life chances (structure): class circumstances and to a less important degree the other variables in box 1, constitute life chances (structure). Life chances are the other most important component of lifestyles (in Webers model). The term is associated with the advantages or disadvantages of relative class situations, including for the purpose of this research, those living on a low income or in poverty. Chances are socially determined and social structure is an arrangement of chances (Cockerham, 2013; 2010) related to social position.

There are arrows indicating a dialectical interplay between choices (box 3) and chances (box 4). This interaction is the most important in the conceptualization of lifestyle construction. Choices and chances operate in tandem to determine distinctive lifestyles for an individual, groups and classes. Life chances (structure), either constrain or enable choices (agency), but agency (choices) are not passive in this process. People have to consider a course of action if their actions are to be constrained or enabled. People therefore align their needs, goals and desires with their probability for realizing them and choose a lifestyle to their assessments of resources and class circumstances. In this context, choices and chances are not only connected dialectically, but also analytically distinct. Even though chances (structure) are dominant primarily because people are socialized and have experiences within the context of the social structures that comprise their world, choices (agency) enters the model at mid-point where choices and chances interact and outcomes are chosen from what is available (Cockerham, 2013; 2010).

Box - 5 Disposition to act (habitus): Table 3.3.1 shows that the interaction of life choices and chances produce individual dispositions to act. These dispositions constitute habitus. The concept is probably most known through the work of Bourdieu, where he explains the relationship agency-structure in lifestyle. Habitus are a “cognitive” map or set of perceptions in the mind that guides and evaluate a person’s choices (agency) and options

(structure). It provides dispositions to act (considered) appropriate by a person's social situation and setting. These dispositions can be acted out even without given them a great deal of thought in advance. They are habitual ways of acting when performing routine tasks. Individuals who have similar life chances (structure) share the same habitus to some degree because they are more likely to have similar shared experiences (Cockerham, 2013; 2010).

Box - 6 Practices (action): dispositions (habitus) produce practices (action). These practises (that result from habitus) can be based on deliberate calculations, habits or intuition. Practices (action) can be so integrated into routine behaviour that they can be acted out unthinkingly. People tend to adopt generalized strategies (a sense of the game) oriented toward practical ends in routine situations, that they habitually follow without stopping to analyse. As a routine feature of everyday life, it is appropriate to view health lifestyles as guided more by practical than abstract logic (Cockerham, 2010; 2013)

Box 7 "the action": the four most common practices measures in the health lifestyle model are alcohol use, smoking, diet and exercise. Other practices, such as use of a car seatbelt and physical check-ups by a doctor comprise other typical forms of action taken or not taken (Cockerham, 2013; 2010).

Box - 8 Health lifestyles (reproduction): the practices themselves may be positive or negative, but they include a person's overall pattern of health lifestyles. It is important to note that the practices (action) have complexities of their own. Action or inaction related to (particular) health practices leads to reproduction, modification or nullification by habitus through feedback processes. This is demonstrated through the arrow from box – 8 to box- 5. (Cockerham, 2010; 2013).

This theory was used to help the researcher formulate the study by focusing on how structure – in this case people living on a low income or in poverty in Norway – influences

the development of habitus and particular health practices by focusing on people's 'choices' in relation to their 'chances'. This is in contrast to much of the existing research that focuses on individual risk factors – box 7 – without seeing these as aspects of the social world. The research question and then the interview schedule and the resulting analysis were coherent with this model.

4. Methodology

4.1 Research strategy, study design and data collection method

Social research involves research that draws on the social sciences for conceptual and theoretical inspiration (Bryman, 2012). In this research project this is motivated by the development and change in the Norwegian society where we can see increased differences in socioeconomic status and a growing population of people living in poverty (Langeland, et.al., 2016) all of which has implications for social inequalities in health.

The aim of this study is to explore how living in poverty influences a person's everyday choices related to health. In order to do so, this study seeks to generate in-depth detailed and rich data, which explores the everyday experiences of people and understands that experience from their perspectives. This research project therefore takes an epistemological perspective with an interpretivist view because this is the most appropriate way to study the social world to generate acceptable knowledge about it because that there is a difference between objects of the natural world and human kind. This study wants to understand the meanings people attach to their social reality in order to understand their social action. A qualitative approach is therefore appropriate because it has a commitment to exploring phenomena in detail to understand experiences from participants' perspectives (Bryman, 2012; Patton, 2015).

The research strategy is founded on the ontological perspective of constructionism, in that people are viewed as constructing their social reality. Constructionism is an ontological position, which implies that social phenomenon and categories are not only produced through social interaction, but are in constant state of adjustment as well. Constructionism invites the researcher to consider ways in which social reality is an ongoing achievement of

social actors rather than something external to them that totally constrains them (Bryman, 2012).

In terms of study design, this was a cross sectional study involving people at one point in time, so providing a snapshot of people's views. The data collection method used was semi structured, individual interviews because it is the interviewees' own perspectives and points of view through rich and detailed answers that is of importance. (Bryman, 2012). A semi structured interview contains themes and open questions that relate to the research question, at the same time it is possible to follow up specific answers given in order to give further detail to people's responses. The interviewer can probe themes that are of interest or importance to shed light on the research question (Kvale & Brinkmann, 2009). In this way issues of relevance to the participants are explored and discussed allowing them to reveal what is salient to them in their everyday lives of living in poverty or on a low income in a rural part of Norway. At the same time, semi-structured interviews will help an unexperienced researcher in conducting interviews, in enhancing confidence and ensure that all topics of interest will be discussed in the interview.

4.2 The process of recruitment

The researcher thought through and discussed several opportunities for how to recruit participants with her supervisor. The researcher decided to try to recruit participants through voluntary organisations who support and help people who live in poverty and with low income. This way the researcher could have an indicator that participants would be in need of assistant/help and were living on a low income. After reading about several local organisations, how they work and what kind of work they do for people with low income (living in poverty), the researcher decided first to contact the Red Cross in Hedmark. The researcher wrote an e-mail to the leader of the organisation, where she explained the project

in short and asked if they were interested in cooperating with recruitment of participants to the project. After waiting for an answer (for about four weeks) the researcher decided to call the head office. It was then apparent the leader (that was listed on their web page) of the Red Cross did not work there anymore. The researcher was therefore asked to send a new e-mail to someone else working in the organisation where they would discuss the matter. The researcher received a phone call two days later where they apologizeds for not being able to help with recruitment. They explained they did not feel they had the knowledge and close relationship with their users to help with recruitment. Instead they gave the researcher names of other organisations in the district that they thought could be contacted and could help with recruitment.

The researcher contacted several organisations in Hedmark by e-mail, among those were the Salvation Army, Stangehjelpa [Stange aide], Frisklivssentralen [Healthy living centres], and Frivillighets sentralen [Voluntary central], in different municipalities in Hedmark. This work was carried out in November/December 2016. The researcher was in contact with nine different organisations all together, by e-mail, phone and/or meetings. Several of the organisations gave the same explanation as the Red Cross, in why they not were able to recruit participants. Some of the organisations informed people they knew about the project who met the criteria for the research; - low income, (living in poverty), adult (over 18), speaking Norwegian, living in Hedmark. They asked if the organisation could give their name and contact information to the researcher so she could contact them. Two of these organisations gave the researcher names she could contact and asked if they would participate in the research project. Al together the researcher contacted seven potential participants by phone call. Those who did not answer received an SMS with short explanation of who was trying to call them, and that they would be contacted again to receive more detailed information. At this point all seven agreed to participate, and all were

given information that they would be contacted again (after Christmas), to schedule time for interviews. One participant withdraw before the interviews were conducted.

4.2.1 Purposive sampling

One of the main ways to conduct sampling in qualitative research is through purposive sampling. This type of sampling has to do with the selection of units, which can, for instance, be people or documents but in this research, were people. The research question should give an indication of what units need to be sampled. In other words, the goal in purposive sampling is to, in a strategic way, sample participants who are relevant to the research question that is being posed, who can give relevant responses to the research question and related issues, and have experiences and views about the topics asked (Bryman, 2012). In this research project, it was important that the sample had experience of living on a low income in Hedmark, so the researcher was able to answer the research question. In purposive sampling, there is often involved more than one approach, for instance in this research project also convenience sampling is used (Patton, 2015).

Convenience sampling, - is when the researcher uses the sample that is available to her, by its accessibility. In other words, it is the people the researcher can get access to and who agree to be interviewed (and participate) (Bryman, 2012). This research project used the people who were available and accessible through the organisations that were contacted, and the people who were willing to participate after receiving information about the research project.

The researcher tried to recruit more than those seven, which resulted in six participants who agreed to participate. As mentioned before the researcher was in contact with nine different organisations. Two organisations managed to recruit participants. Two others tried to recruit participants, and five organisations did not feel they could contribute.

Since this is a master theses and there is limited time available the researcher needed to go forward with the project and accept the number of participants. This is a limitation that will be discussed in chapter six.

4.3 Development of the interview guide, piloting and consequences

The review of literature relating to living on low income and in poverty informed the development of the interview guide (se appendix 1). Literature about how to formulate and ask interview questions also informed the construction of the questions in relation to how to make open ended, short and clear questions, and how to use probes and follow up questions to secure a rich and detailed description from the participants. These themes and knowledge helped the researcher develop the guide. The researcher also had meetings and discussion with her supervisor regarding the development and formulation of themes and question in the guide. Some of the questions asked were: Can you tell me a about how you experience your health, both physical and mental? Can you tell me about your financial situation today? Can you tell me anything about what things you prioritize, and / or what things you would like to prioritize?

The researcher conducted two pilot interviews. This lead to some changes to the interview guide, with a few additional questions, and some questions was reworded to be more clear and precise. The question added was about life quality (If the interviewee felt, they experience to have a good life quality and what might contribute to that?). This question was added because in the two pilot interviews this came up as a topic. Life quality and health is strongly linked and influence each other (Erikson & Lindstrøm, 2007). This question could therefore shed light and give a broader/deeper description on how the participants describe their lives. The interview guide also contained a background question. In the piloting these questions came at the end, but when beginning the interviews with the

participants the researcher moved them to be the first questions. This was because it felt more natural for the researcher to begin by asking the participants about their background. It also allowed the researcher to get some knowledge of the participants before starting on the questions that would help answer the research question more directly.

4.4 Interview and interview guide

Under the three first interviews the researcher followed the interview guide thoroughly, ensuring to ask all the questions and what kinds of probes and follow up questions to use. When the researcher had done three interviews, she was more familiar and more secure in the interview setting, and therefore did not need to use the guide so carefully to do follow up questions and, in some interviews some of the question stated did not need to be asked because they had already been answered.

After the two first interviews the researcher changed the interview guide slightly. This was because the two first interviews lasted a very long time (six hours all together). One of the main reasons for this was because the first question asked were: can you tell me about yourself, your background and such? The two participants used up to one hour answering only this question. To try to shorten the length of the interviews a change was made to the background question. At first this was a broad open question, where the participants could talk freely about where they came from, work experience, family and such. The change was that the background question was more concrete, and the researcher asked for a short description and asked; where are you from, age (which year are you born), children/family, housing (own/rent), education and work. This did not change any of the other question in the guide. Since this was background information the researcher still managed to get to know the participants a bit, and it did not seem to have any consequences

for the analysis. The researcher also removed one other question about opportunities, which felt redundant in that no relevant information was generated.

The researcher considered if the interview guide (might) contain(s) too many questions. This was because, even though there where made some changes to the guide, - to try to shorten the time, the last four interviews lasted about two hours each. The estimate for the interviews was about one hour, (the two pilot interviews lasted 1,45 and one hour). This resulted in many hours with transcription and about 160 pages' transcripts. This could influence the analysing process, by making it difficult to code and find themes if the participants have talked about themes not relevant for the research. It can also be a strength in, - that the participants have given thick and rich data (description). The length of the interviews might also be a limitation and will be discussed in the chapter six.

Under transcription the researcher noticed, in several interviews, topics and answers where she should have probed and asked follow up questions for a broader understanding and for securing the meaning of the content (in the answer). This can influence the analyses and result. This is a weakness the researcher need to consider when analysing the data. If the researcher was more experienced this might not have happened.

4.4.1 Interview situation

The researcher received approval from NSD in the first half of January 2017 (se appendix 2). The interviews were conducted in the end of January and beginning of February 2017. It was the participant who chose the time and place for the interview in order to make the interview setting as comfortable as possible for the participant. It was important for the participant to feel secure and at ease (as much as possible), so they felt it was easy and safe to talk (Kvale & Brinkman, 2012). This was vital in this research project when the research

question and themes explored during the interview were personal and could be considered sensitive. They could generate feelings of shame and discomfort.

The researcher thought she developed rapport with all the participants and the talk was natural as in a conversation. Before beginning the interview the researcher gave the participant written information and a consent sheet for them to sign (se appendix 3). Two sets were signed, one for the participant and one for the researcher. The researcher informed all the participants that they had the right to withdraw at any time, because one cannot anticipate feelings about participation, and some parts of the process might be disturbing (Oliver, 2003). The researcher also gave information about the use of tape recorder under the interview. The participants received information about if there were questions they did not want to answer, or needed a break, they should just let the researcher know. The participants were also given the opportunity to ask question before beginning the interview. Several of the participants asked for brakes under the interview (cigarette and toilet brakes) but none had questions prior to the interview.

Respondents' credibility was to a certain extent secured when the researcher made small summaries and asked if she had understood the respondent correctly through her interpretation.

The researcher had scheduled that the interview would take approximately 1 hour. This estimate failed in all interviews. The longest interview lasting three hours and 45 minutes, and the shortest, one hour and 45 minutes. Five out of six interviews were conducted in the homes of the participants, the sixth in an office in the building of the organisation that helped with the recruitment.

4.5 Description of participants

All the participants were ethnic Norwegian. There were five women and one male. The participant's pseudonym, age group, education and work situation is presented in Table 4.5.1 below.

Table 4.5.1 The participants' pseudonyms, gender, age, educational background, and work situation.

Pseudonym	Gender	Age Group	Education	Work situation
Hilde	Female	55-59	Unknown	Disability insurance /social payment
Jenny	Female	60-64	Vocational	Unemployed / work assessments allowance
Trine	Female	35-39	Vocational	Unemployed / work assessments allowance
Kari	Female	45-49	Bachelor	Disability insurance / social payment
Toril	Female	45-49	Vocational	Unemployed / work assessment allowance
Jan	Male	65-69	Vocational	Disability insurance / social payment

All the participants, as table 4.5.1 shoves, were involved with NAV (Arbeids- og velferdsetaten), the Norwegian Labour and Welfare administration. None had paid work at the time the interviews took place. Three of the participants was in recipient of disability

insurance (uføretrygd),- the other three had work assessments allowance, all three of these had applied for disability insurance. Five of six of the participants were smokers, and five of the six had a physical injury that leads to pain. All six participants also had psychological illness and/or difficulties. In table 4.5.2 is the social situation of the participants presented.

Table 4.5.2 Participants' social situation

Pseudonym	Children/Grandchildren	Housing	Car	Pet(s)
Hilde	6/3	Public housing	Yes	Non
Jenny	2	Renting	No	Non
Trine	0	Renting	No	Cat and dog
Kari	3/1	Renting	Yes	Dog
Toril	0	Renting	Yes	Cat
Jan	3/1	Own	Yes	Cat

4.6 Analysing the data

Even though some of the interviews were very long, the interviews were transcribed verbatim and subsequently analyzed using an approach called thematic analysis. When doing thematic analysis, the aim is to extract core themes that can be distinguished within and between transcripts, in order to organize and describe the data set in rich detail. These themes were identified through coding each transcript. Coding is a process where data are broken down into essential parts and these parts are given labels. The researcher searches for reappearances of these sequences of coded text, within and across transcripts, but also for links between codes. In this process, the researcher makes sense of the data through coding, through a process of interpretation. The researcher seeks to link the analyzing process to the

research question, as well as with the theoretical ideas used to highlight the issue. (Bryman, 2012; Braun & Clark, 2006). In this research project the theory of health lifestyle of Cockerham was used to highlight the issues to sensitize the researcher to what might be useful lines of inquiry that could guide the analysis and interpretation process. It is the quality of the theoretical reasoning that is made from the qualitative data that is central to the concept of generalization (Bryman, 2012). This means that theoretical explanations might be generalized beyond the specific situation studied. The issue will be explored more fully in chapter six.

4.7 Researcher pre-understanding

Pre-understanding is often an important aspect of the researcher's motivation to start with research on a particular topic. Pre-understanding is the understanding and knowledge the researcher brings with him or her into the research project. This influences throughout the way the researcher collects and reads data. This is something, that at best can nurture and strengthen the project, but which at worst can become a heavy burden, that makes the researcher not see the things she meets on the way. If the researcher has an active and conscious awareness toward her pre-understanding the benefits can be enhanced and the negative aspects reduced (Malterud, 2003).

The researcher in this research project has through her education and work practice as a nurse, and now as a master student in public health science, been concerned with people and people’s health. Especially during the master program the interest and curiosity for people living in poverty has grown. The researcher has gained significant information and knowledge about this topic during these years. The preparations for this master project and review of the literature on the problem area has led to greater insight into how poverty can influence people’s lives. This has influenced the researcher’s pre-understanding when she

has formed a view on how low income influences health. The researcher was conscious of and reflected on her pre-understanding during the work with this master theses and have tried to put it aside by being as objective as possible. This has also been discussed with the supervisor who has help the researcher to be more reflective, especially to words this subject. For example, the researcher has during the research process been more aware of how she talks, think and speak about people with low income or people who live in poverty.

4.8 Ethical considerations

In this research project the data collection that was conducted were from people. This raises questions about how these people should be treated and such questions are often ethical.

In this research project one of the first issues was what terms to use to describe the people who provide data in this research project. The terms used carry implications for how the researcher views people and their role in the research project.

The term participant was therefore used in the participant information sheet, consent form, as well as in this master thesis. The term participant indicates that something is being carried out in concurrence with people (Oliver, 2003). This issue was particularly important in this project because participants that was recruited are potentially vulnerable and are more likely to have a lower social position than the researcher.

It is unacceptable to conduct research that can harm the participants. Harm can entail many facets and in social research the potentially adverse consequence can be difficult to predict (Oliver, 2003; Bryman, 2012). The themes discussed in this research project are personal, and could be considered sensitive, some subjects could also evoke strong feelings as participants talked about their everyday lives that could be both difficult and stressful. Therefore, were participants given information that if there were questions/themes they did

not want to talk about or answer they did not have to respond or let the interviewer know that it was a difficult subject to talk about (Oliver, 2003).

The principle of informed consent means that the research participants should be given as much information as needed to make an informed decision about whether to participate in the study or not (Bryman, 2012; De nasjonale forskningsetiske komiteene, n.d.). In this research project the participants received oral information about the study before they answered if they were willing to participate. All participants were given the opportunity to receive written information ass well, but declined. Before the interviews were conducted all participant receive a written consent form, with short information about the project. Including information that data would be recorded and how it would be handled, their right to withdraw at any time from the project, without any consequence for them and/or their organisation, and their relationship. The respondent and researcher both signed the form and retained a copy. Because the level of education of the participants might be low, all written and oral communications with potential and actual participants was carried out using everyday language.

A tape recorder and voice recorder on the researcher mobile phone was used to ensure the accuracy of the actual words spoken in the interviews. This ensured that important matters of emphasis and pauses in the dialogue when transcribing the interview (Oliver, 2003) were also noted. After the transcription, the audio files were stored on a coded phone, (the files on the tape recorder was deleted and given back the university library). When transcribing, all the participants were given pseudonyms and their age is mentioned, not in a number but in a group (for instance 35-39). Descriptions of places were altered, if included as a quotation, to ensure anonymity. A limited amount of sociodemographic information was collected about each participant so it would be hard to identify anyone. All data was deleted after the project was concluded. All quotations used were translated from Norwegian to

English. This aspect can change the meaning of the sentences even in small or subtle ways. This is a weakness the researcher was aware of and tried to minimise through discussions of quotations with the supervisor and co-workers (students).

There was also important for the researcher to bear in mind that the tape recorder could be intimidating and worrying for some people. To try to reduce these feelings the researcher informed and explained the use of it and placed the recorder between the interviewee and interviewer so the participant could push pause if needed (Oliver, 2003). However, this was not needed in this research with these interviews.

One principle in qualitative research ethics is that: “Research should be designed, reviewed and undertaken to ensure integrity, quality and transparency (Bryman, 2012, p. 144). To ensure transparency and qua lity in this research project the method section, the chapter of analyses and results have been described as detailed as possible and ethical issues have been discussed and thought trough, before, during and after the interview process. In social research projects, it is also important that anonymity and confidentiality is respected (Bryman, 2012). The researcher has throughout this chapter tried to explain and show that qualitative criteria’s and ethical principles have been obtained/ secured. (Approval from NSD, information sheet and consent form are attached, see appendix).

All methodological choices were made with dew regard to working systematically and scientifically. However, like all research the study hade a number of limitations, which is fully explored in chapter six.

5. Presentation of the findings

5.1 Understanding how people living in Norway in poverty make health choices

In this chapter, the findings from the qualitative interviews are presented in a way that illuminates the research question. The research question is: “How does living in poverty in Hedmark, Norway, shape people’s everyday choices related to health”? In order to answer this question three themes and seven sub-themes were developed that were grounded in the data. In order to provide an overview of these they are presented in Table 5.1 below.

Table 5.1 Presentation of themes and sub-themes found in the analyzes.

Theme	Sub-theme
Health as knowing and doing	Feeling healthy and having ailments
	Vicious circle
	Understanding that health is important
Feeling isolated	Limited social network
	Limited financial resources for social interaction
Financial worries as a life sentence	Limited opportunities for choices
	Spending money on necessities

In the following section, each theme is presented through rich description and anonymised quotations from participants to illustrate the themes. The quotations are translated from Norwegian to English with focus on keeping as close as possible to the meaning expressed by each participant. The possible limitation of these translation are discussed in chapter 6.

5.2 Health as knowing and doing

Participants talked about health, what affects health in a good way, and what affects health in a negative way. They also talked about what they must do to have a good health or to improve their health. Diet and physical activity were both identified as being important in this regard. Half of the participants said they eat unhealthily and had bad diets and eating habits, at the same time saying they should eat more healthily and have a better diet. The other half of the participants said that they ate healthily and seemed to be more aware of what they ate. However, all participants said it was difficult to eat as healthily as they would like because healthy food, such as fruits and vegetables, chicken and fish were perceived more expensive than food hat was not that healthy. At the same time, those who said they ate healthily were likely to spend more money on food than the others, and they also said they like to cook. Those who said they had a poor diet said they did not like to cook that much. The linking of cooking with enjoyment therefore seemed related to the extent to which participants had a healthy diet. Toril described it like this:

> "My diet is poor, usually it's coffee, as I said, and then there is usually food in the afternoon and evening ... I'm very bad at making dinner … If I buy something then there's plain food, not a steak, even though I would really like that, because I haven't eaten it for so long … but no, it's probably more that I'm not the "house", or the one who likes to cook, no so it's a combination yes"

In talking about health, participants also talked about physical activity and that it was good for health. Two of the participants (one had a dog) said they go on longer walks daily, up to one hour, whereas most others said that they should be more physically active, should train more, as they should be doing it for their health. When they talk about this they are especially referring to their physical health. Most of the participants explained that they could not afford to train, because they could not afford to go to a fitness-centre or have a personal trainer. At the same time, it was not just the cost that was keeping them from training (or being physically active), but more about how their situation made it difficult to organize themselves so it became a daily part of their routine, as Hilde explained:

> *... "I know what I ought to do and should have done, but nevertheless, it is a but, I cannot just blame, I cannot just blame that I cannot afford it, it's possible to do a lot at home too, it is possible to work out at home as well, but it's just that to take a hold on one self, make it a habit like when you brush your teeth, I'm too blunt/apathetic to"*

In the theme health as knowing and doing, three sub-themes were developed: feeling healthy and having ailments, vicious circle and understanding that health is important, which are explored further below.

5.2.1 Feeling healthy and having ailments

Participants tended to evaluate their own experience of health as good or strong the reasons given relating to rarely having a cold, the gastric flu or that they believe they have good blood pressure. At the same time, participants stated that they had one or more ailments, physically and/or psychologically, in most cases they had their injuries/ailments for many years. These conditions related to stomach problems, a damaged arm, neck, shoulder

or back. Several people also talked about mental illness, most commonly referred to as anxiety and depression and this was often experienced alongside physical problems. The experience of illness and living with ailments did not necessarily prevent and evaluation of health as poor, as this quotation from Jenny explains:

> *... "but now lately I've experienced a lot of pain in my feet/legs when I walk a lot and stand a lot, so I have to resort to some painkillers for that as well, but otherwise my health is fairly good, I have no long-lasting disease besides a bit of high blood pressure I have had ... I am feeling tired, I feel it's ... it has been a lot in recent years that has mentally broken me ... otherwise I believe to be in good health, I rarely have a cold, I'm never cold ... so my weaknesses through time is my shoulders and arms, I've had a strong back, and yes you can say strong feet too but ... and the stomach I've been a lot bothered with" ...*

However, some participants said they did not have good health. One participant explained this first and foremost because she was living with physical pain every day which affected not only what she could do but also the quality of her life. Kari explained it in relation to her mental situation where she struggled with anxiety to the extent that she isolates herself inside her home, she said:

> "I know that I hold back and that I isolate myself, but that's what I need to do right now, but that's okay, but it makes it quiet then, so I spend a lot of time to, I found out one time I was hospitalized that if I knit and watch movies at the same time it derives some anxiety" …

5.2.2 Vicious circle

Four of the participants found it difficult to do something, or change something in their everyday life and/or in relation to their health. They explained this in terms of being in a vicious circle. By this they meant that even when they know what they ought to do, should and could do to improve their health and their situation, they cannot manage to do so on their own. The consequence of this was that, they feel overwhelmed by things and not in control of what is happening to them. This makes it more difficult to adapt and cope when the next thing comes around. Participants also found that their physical and mental health was linked as a two-way process, one affecting the other in both directions. Toril explained it like this:

> ... "it's like, yes, I know what, I know wat one should and could, but, but it's always this" …

Hilde described it like this:

> ... "for the last three years, I feel like I just only had my head over water and been struggling to get enough air, and then gone under again, or like every time there's been a new thing, that just. In a way, I haven't been able to stand again after each time, it's like I'm almost waiting for what comes next" …

Participants poor financial situation was viewed as contributing to this vicious circle of not being able to change the direction of their lives. With regard to health specifically and diet in particular, sometimes they were not able to buy enough food, or not able to buy as healthy food as they wish or want and their diet tended to become monotonous in these circumstances. Kari was one of those who experienced this, and explained how this affected her and became a vicious circle in her life:

> ... "it affects the physical health, you know, which again affects the mental health, and then you have the ball rolling" ...

5.2.3 Understanding that health is important

Participants viewed health as being important to them, that one should take care of one's health. Jenny described it in a good way when she said, "a good health contributes to the fulfillment of dreams", that reflects an overall understanding of health. Nevertheless, five out of six participants smoked. The participants viewed this as stupid, because it harmed the body and they were aware of the health risk caused by smoking. They also said it was expensive and that they spend a lot of money on smoking. Trine said, "I'm literally burning up my money". All the participants who smoked talked about smoking less than previously so they were spending less money on smoking. Others said that they were trying to quit smoking, but they experienced it as very hard. However, smoking had a purpose in their life and therefore they were unable to quit. The purpose was in terms of coping with a life that was often overwhelming to them, Hilde for example explained:

> "I'm fully aware that it's ruining a lot, but it's my nerve pill" ...

Participants tended not to drink or hardly drank alcohol either because they said they could not afford to or because they did not want to mix alcohol with the medicine they took. Smoking was therefore seen as more acceptable, because it was perceived as serving a purpose even though it was expensive and harmful. Alcohol on the other hand was something that did not really fulfil a role for the participants which meant that they were unlikely to spend money on it, because it was expensive, as well as being harmful to health

and sometimes making them feel worse about their situation. This is illustrated in the following quotation from Jan:

> ... "Alcohol isn't good, I'm very careful with it, the only thing I can buy is some beer, to enjoy myself, cause you only get drowsy by it, liquor I can't drink, then I get, oh no, I'll get so many weird thoughts then, and you become someone you're not, you should not be"...

Four out of six participants experienced a low level of quality of life because of their health and financial situation, and the experience of isolation was related to this. A higher degree of security and predictability in everyday life was seen as contributing to an increased sense of quality of life. In turn securing, predictability and joy were viewed as relating to having someone in their lives, animals and/or people who matter. These were seen as the foundation of having a good quality of life. Trine described it like this:

> ... "you are in a way deprived of some quality of life, is it correct to say? When you are in such a situation, and you cannot actually choose to work, so some quality of life am I in need of as well, and then I prioritize my pets"...

5.3 Feeling isolated

All the participants talked about feeling isolated in various ways, even though they talked about liking to be alone, watching television at home for example, and being comfortable and able to thrive in their own company, as well as liking – or at least being ok with being at home. When participants talked about feeling isolated they explained it in

terms of feeling separated from society because, as Kari declared “everything costs money” in one way or another. This theme therefore illustrates that their capacity to participate socially was perceived to be restricted by their financial position. Therefore, two sub-themes were developed to explain their feelings of social isolation in more depth: limited social network and limited financial resources for social interaction. Trine, explained it like this:

> "I'm not very social but I have no desire to become more social either, I am comfortable with how it is now, so the few close friends I have and my family, it is in a way fine"

5.3.1 Limited social network

It was evident that participants felt isolated because they had limited social network of friends and family. Participants talked about having few friends in particular, and how it tended to be like that their entire lifetime. Although having a limited social network gave rise to feelings of isolation it was sometimes viewed as being the way they wanted things to be. This was explained in terms of it being important for them that the people around them knew them, because it brought stability and security. This indicates that the value of social network for these participants was in terms of the quality of the relationship rather than the number of people with whom they were in contact with. This issue was particular important for those who were struggling with anxiety and depression. Kari, who struggled with anxiety and depression explained it like this:

> “very often, is the fear of the anxiety almost more prominent than the anxiety itself, so it’s when I know the days are more or less 100% predictable, it's much easier to cope with, so I need it in a way. Have people around me that I know, who is stable, safe and caring people” …

It was important for participants that friends in their social network knew them and their situation, particularly in relation to mental health issues. However, opportunities to make new friends were also taken. Some of the participants said they experienced being lonely. They wished they had more friends, as well as more contact and company with friends. They experienced spending much of their time alone. Participants described that having so little contact with other people made them feel depressed, and that again made them feel worse about themselves. Hilde felt this on her body and described it like this:

> … "you could have had it better if you had, if you had the opportunity, both financially and other things, so you become very, very lonely and I'm very social so that suits me very badly … I say it suits me very badly to be so isolated because then I actually get a diagnosis and it's depression, it's tough" [she cried a bit].

Participants had contact with close family members such as parents, siblings and /-or children. Contact with family was generally seen as important to participants, although it varied how good the relationships were perceived to be. Loneliness tended to be experienced by those with few friends alongside limited contact with their family, especially when their family lived far away. However, even if family members were living in the same area, participant could still have no close relationship with them. In these kinds of circumstances having one close friend who, for example, was seen almost every day could be very important. Friends were generally seen as less important if participants had good contact with their family. For example, Kari says:

> ... "I have no circle of friends to claim, or people I talk to on the phone or, I have my kids, and I have my parents" ...

Over all, the feelings of isolation were diminished if participants had at least some social network that was composed of friends and/or family, and such were seen as important in not only reducing isolation but also providing company at low cost and support. Also, being able to participate more in social events outside the hose would lower the feeling of isolation.

Four out of six participants had pets in the form of dogs and /or cats. All those who had a pat described them in terms of them being one of the most important things they had in their lives. They viewed them as helping them by being a source of positive emotions in their day to day lives giving it meaning and feeling of joy. Similar to the way friends and family members were viewed, pets were a source of company whom they could talk to, care about, but who did not require anything special in return, or make unreasonable demands on them. Pets could also help them structure the day through ensuring that the animals received food first and, in the case of dogs, were taken for walks. They also reflected that they actually did not have the money to have animals because they were an additional cost. However, the pleasure and the company they had with the animals was evaluated and viewed as worth the expense as they would not live their lives without their pet. Trine who had both a dog and a cat, expresses it like this when she talked about her dog:

> .. "but it gives a lot, so it's much better to use the money it costs a year on him than not to have him, so it gives a lot more than it takes" ...

5.3.2 Limited financial resources for social interaction

Feeling of isolation were related to being unable to afford to participate, especially in social and cultural activities, such as going to the cinema, a concert, join friends at a cafe, or

eat out at a restaurant. Thus, participants' financial situation restricts their social lives and participation. Jan, for example explained that social activities could not be prioritized above living expenses:

> … "I usually stay at home, yes, I cannot afford to go to a cinema or something like that, I think it may be 6-7 years since I was at a cinema ... very rare that I am with someone out on the town, because I cannot afford it, if I'm to pay for the taxi ride home as well, it is 500kr, and that is the money I have to live off "...

At the same time, participants felt that asking friends or family over for dinner also became an extra financial burden. They had to buy food for several people, and they usually buy something extra as well as tending to buy more expensive food. This prevented participants from asking friends/family home for dinner, which they would like to do, which then in turn gave the rise to feelings of isolation.

5.4 Financial worries as a life sentence

All participants experienced their financial situation as difficult, meaning that they had too little money to cope with everyday life, particularly in terms of doing things that give everyday life meaning and joy. Furthermore, the economic situation was perceived as worrying as they did not see how it could become better or changed. This meant that their future lives would continue to be limited in terms of hopes and opportunities and were likely to get worse, Trine described it like this:

> ... "what's a little un-cool to think about is that my future is financially damaged, for the rest of my life, that is in a way a depressing thing to think about, it's never going to happen that I get a loan to buy a house, I'll never going to have that opportunity" …

All participants received their money from NAV, either through disability insurance or work assessment allowance. All participants found that cooperation with NAV was difficult in that there was little understanding and help available. This was perceived as frustrating and was an additional burden for them in their everyday life. NAV was perceived as controlling them, especially in relation to what they spend their money on, something they experienced as a lack of confidence in their ability to manage their lives. Their financial situation was viewed as making them vulnerable, and few could see any opportunity for improvement or change in the form of their future financial situation. In this way, it can be understood as a life sentence. Several of the participants mentioned that if they only could receive a thousand (NOK) more a month, it would help them to a lot with their monthly expenses.

The topic of financial worries as a life sentence is explored in more detail through the following two sub-themes: limited opportunities for making choices and spending money on necessities.

5.4.1 Limited opportunities for choices

The participants did not have the finances to do the things they wanted, buy the things they needed or wanted, or to participate or inter act in things they wanted to do (both those things they have done before as well as new things they would like to do). There was, in particular little room to save money, particularly when some have debt collection fees, and

others have things on pay off. These financial limitations meant that their opportunities to choose what they would like to do were similarly limited. For example, they talked about being unable to work with their hobby, or participate in activities such as cinema, swimming, concert, travel, or take a vacation. Commonplace activities such as going to the hairdresser often could not be afforded. They experience their economic situation as depriving them of opportunities to live an active life and participate in society in the same way as others. Trine tells:

> … "but you lose a lot of opportunities because ... you are not able to go on holiday, for instance, if there is any offer on any clothes or what it should be, whether it's at the store or, so if I do not have money then I don't have the money then, I'm trying to make the most of the offers" …

People described how they found it difficult to go to the store or mall because there were many temptations, offers, clothes and things they would like to buy but could not afford in their situation. If they did buy something, they then go beyond the money they have to spend on food and bills. Toril said that:

> ... "I am very low on things now, and I haven't, I really do like to go to shopping malls and things like that, but now I haven't done it by will because I haven't got the money for it, and the temptation becomes too big" ...

Living in a poor financial situation was perceived to be tiresome, because it was always a matter of finding offers, shopping on offer, finding the cheapest, and always resisting temptations (which was everywhere). Kari explained that "one must always be on"

meaning that there was never a break, one must always think about what one is spending money on, what one chooses to buy now, and one must always make a decision about what is most important to buy. Some events were particular challenging to deal with because their economic situation made it difficult to buy gifts for family and friends for Christmas and birthday. Trine said:

> ... "so it's a little like, that you get a bit tired of thinking about it all the time" ...

5.4.2 Spending money on necessities

Participants everyday lives involved always prioritizing their spending on fixed costs, where rent or loan for the house/apartment was the most important thing to pay first. This was seen as important because it contributed to security and stability. Then power/electricity, phone, TV, internet, car loan (for those who had it) and insurance were prioritized. The participants spent most of their money on these expenses and it varied how much a person had left for food, household and any other bills. The most common amount they had left after the fixed expenses were paid was between 4-5000 NOK (some lower, some slightly higher). The pattern of spending among the participants reveals a prioritization of necessities leaving very little for available to choose non-necessities, Jan described it like this:

> "No, I have a certain amount of money in the month, and out of that goes 2/3 on fixed expenses and so, then it's gone, there's an autogiro on everything, so around the 20-21, then I have so much to live for, so that's why I'm saying if I'm going to my doctor or something like that besides them, the money left, which I'll have to live off, I'm getting anxious because I cannot afford it, because then I'm

> “eating” of the money that is left for food and fuel for my car and so one, and at all, otherwise I'll just have to stay at home" …

The remaining money should cover food, medicine, doctor visits, household goods such as toilet paper and green soap, clothes and shoes, and so on. Many of these items over time are ones that will need to be replaced. Those who have animals must also pay for food for them, as well as the veterinary or any other expenses that comes with an animal. Participants state that they shop when things are on offer, ranging from food to clothing. Kari said that:

> ... "It's the cheapest, always the cheapest it can take forever to shop because I constantly go and compare shelf prices ... so I am into all of the customer programs and discount arrangements and ... I am in on all that to try and pull or stretch the money to make them last as long as possible” ...

In spite of being careful with expenditure, participants said that there was never money for anything extra, never money to do anything fun or enjoyable. Most people go with a worry and fear and several of the participants talk about anxiety for envelopes. Meaning they get worried when there were letters in the mail, worried if there were bills, debt collection or claims they were unable to pay.

6. Discussion and conclusion

6.1 Explaining how living in poverty influences health choices

The aim of this master thesis was to understand how people in Hedmark with low income live their lives, understand how their choices are made and what might be the implications of this for their health. Through rich and detailed data, the researcher has gained an understanding of the hardship and wearisome everyday life these people experience, with little prospect of their circumstances improving. Being on a low income tends to lead to being isolated and not able to participate in ordinary life activities, such as going to the cinema now and then, or to a café with friends or family for coffee. It also means it is difficult for them to eat healthily and be physically active, because everything costs money that they have had to spend on other things. The researcher gained a lot of knowledge and understanding of how these people lead their lives, how their lifestyle is shaped by their low income, how, for example this, influences what they are able to afford at the grocery store and how their money only covers their fixed expenses as well as how their low income directly and indirectly influences their health, because, for example, they cannot afford healthy food, which influences the body in a negative way. Similarly, they cannot afford to go to a fitness centre and train and become healthier, and they do not manage to work out on their own (vicious circle) and all these things again influences their mental health, which again influences the physical health (another vicious circle), and they do not get the help or support they need to get out of this trap.

Although this study has strengths and limitations which are explored more fully below, it has contributed to the body of knowledge in number of ways. The strengths were that it generated rich detailed data from people living in different municipalities in Hedmark

and qualitative research also contributes to diversity and nuances in the body of research. Qualitative research can also help to bring to light phenomena that have been little studied. As far as the researcher know it is one of few (if any at all) qualitative studies interviewing people living in Hedmark (a rural and relatively poor area of Norway) seeking understanding through lived experiences on how living on a low income might influence health in a country where there is an expanded welfare state.

6.2 Using health lifestyle theory to explain how living on a low-income shapes health choices

Even though all eight boxes (see Table 3.3.2) are important (and influential) in the health lifestyle theory, this research especially focuses on box three – life choices, box four – life chances, and the interplay between these boxes (and box six – disposition to act). According to Cockerhams theory, health related actions, the so-called 'lifestyle' (or practice) is based on choices from options available to a person. Throughout the findings chapter participants from this study expressed that their options or choices were very limited directly because of their low income. Given that Norway is a social democratic country with an expanded welfare state this is a point worthy of note: it supports people according to a basic level but does not seem to allow them to participate in society in the way that Townsend describes (1987). Cockerham states that it is life chances (structure) and life choices (agency) that influence social action, and it is crucial to understand the linkage between these two phenomena because it is the basis where society and social interactions are constructed (Cockerham, 2013b). The health lifestyle theory emphasises that health lifestyle choices are voluntary, but that a person's life chances either empower (a person has many choices and opportunities, often created by being in a good financial situation – in other words, having money that more than covers the necessities, give you options on what to do and how to spend the extra), or constrain (few, if any at all, choices and opportunities, often

because of a limited financial situation which requires that necessities are prioritised above other things that are not absolutely necessary), these choices (Cockerham, 2010). These choices and chances interact. Thus, a person on a low income has few life chances meaning, he or she, is constrained or disempowered in terms of how they might choose to act. This means that they have limited choices to, for example, buy what they would like from the food store or pay out for a gym membership. These are common everyday practices for those who do not live on a low income. The participants also felt constrained in that they were not able to work with hobbies or other interests which for many created a feeling of hardship. They were neither able to go on vacation, because they could not afford it. There was little ability for the participants to go out and enjoy life and spend money on non-essentials, because most of their money went to fixed costs, and the money that was left was needed for food, household goods, doctor visits, medications and so on. This meant that if they spent money on non-essentials it would hinder them to pay for important bills or they would struggle to have food on the table in the end of the month, therefore were their choices constrained by their options.

The choices available to people living on a low income do not just work in the here and now, that is to say, in the present. They also work in a way which constrains choices for the future. Living on a low income meant that they were preoccupied with managing on a day to day basis, because they had little opportunity to plan for the future. Furthermore, low income was fundamentally disempowering because they were trapped in a ‘vicious circle’ with no opportunity to change their circumstances. This vicious circle was also linked to health outcomes, where participants felt that psychological health problems influenced physical health problems and the other way around, making it very hard to make changes regarding health as well.

It is not only that their physical health is likely to be compromised – not being physically active, not eating healthily, smoking and sometimes drinking – but also their mental health was undermined. They talked about isolation, and the hardship of their lives, with no prospect of improvement. Not being able to eat healthily because of low income and healthy food is more expensive. At the same time the money they actually had to spend on food was very limited, constraining the options of things to choose in the food store and always searching out the cheapest foods.

The participants knew that physical activity was good for health, but they did not have the money to participate in any payed activities or join a fitness center. Even though several talked about having the opportunity to walk or be active outside on their own, this was often difficult for them because it is something you do on your own, and the participants felt they were in need of support for being able to be active. Being on a low income therefore constrained their options to be active as well.

Many of the participants felt that having low income and not being able to pay for healthy food, and be physically active influenced their mental health which again influenced their physical health. Their mental health was also influenced by the isolation the participants felt, by not having many friends and at the same time not being able to be with or participate in activities or arrangements with them because of their low income. Their low income did not give the participant the opportunity to choose to participate with friends, because then they could not afford to buy food late, for example. Even though some of the participants choose to have a pet, even though they could not afford it, they felt having a pet gave them joy and it also kept them company, meaning they did not feel quite as isolated. One can say having a pet made them healthier in that it is a companion, and those with a dog also need to be physically active when walking the dog (something they would probably not be doing without the dog).

The participants talked about the importance of good health for having a good life and being able to do what one wanted to do, but at the same time they were smoking, and aware of the health risk this had. It was also something they spent a lot of money on, since it is quite expensive to smoke. The participants explained that smoking had a bigger meaning in their life. Smoking can be related to the health lifestyle model in that it is a practice or action, a habit, and one can argue that it is a lifestyle guided by practical logic since it is something helping them cope and manage the day. One can argue the same about alcohol consumption, which was mostly seen as health damaging and expensive, and was a habit seldom practiced or practiced not at all.

The circumstances (chances/structure) for the participants are that they live with low income which creates a particular socioeconomic position and a set of circumstances that reflect that position. This position influences their life choices in the way that they have restricted or few choices and chances, for example, with regard to grocery shopping.

The participants in this study and all other people are individuals, but they are so in a society with other people that they interact with, and are influenced by, and the choices and chances are as much involved and influenced by this

6.3 Comparisons with other research

A lot of the findings from this study are supported by the existing literature from many other countries. Graham (1989) found that women living in households with low income spent less money on nonessentials goods, but more on cigarettes compared with other households, even though aware of the health risks of smoking. However, they explained the reason for smoking was a coping strategy it was something helping them through a difficult day. Graham’s work between 1989 and 1999 in England remains relevant to this research in this regard. In this research owning a pet fulfilled a similar coping role, in

keeping them company and sometimes being viewed as their best friend and therefore contributing to better mental health This and other research has shown that people living on a low income cannot afford luxurious ways of de-stressing and they often find themselves feeling isolated. Smoking or having a pet is a way for them to manage or cope with difficulties in life and isolation at a relatively low cost and therefore fulfils an important health supporting role as an everyday practice.

Blaxter (1997) argues that people tend to take a lot of responsibility for their own health and lifestyle, especially people on low income. This was also seen in this study in two ways: first, that people tended to talk about knowing that they should eat more healthily and be more active and second, that they managed their money responsibly in order to ensure that they met all their expenses. However, there was seldom talk about structural factors. People tended to talk about the way that it is the shortage of money that constraints them, not why they were in that position. Because people tend to take such responsibility for their health they tend to view their health as their individual responsibility and try to give some priority to it. This is similar to today's social views that have earlier been described by Cockerham (2005) and Crawford (2006). When talking about health, participants from this study as well as from Blaxter tend to claim they have good or OK health, even though they at the same time talked about injuries/ailments and problems that could hinder them in doing daily activities.

This can also be related to the findings in the Macintyre et.al (2004) study where participants talked about health inequalities between differing socioeconomic groups and the poor did not believe thy had worse health than anybody else. The findings in the study of Calnan and Williams (1991) is also supported in this study with regard to people believing there is a link between behaviour (practices) and health, and that even though people have the knowledge that, for example, a practice is unhealthy (smoking) they do it anyway. This

can be understood in a social context of choices and chances because such practices fulfil particular purposes and therefore become established in the everyday experience of people (Cockerham, 2013) such as coping.

Even though participants talked about knowing what they should and could do, and live with aliments, they also talk about it being hard to change practices (behaviour) Stjernø (1985) also talks about this in his research, even though he describes it in a slightly different way when he says something about it being hard to rebel against. Pampel et.al., (2010) also talks about this, that health practices can be affected by motivation or incentive, however, at the same time they stress the importance of the unique dimensions these practices have. Cockerham’s model provides a better explanation for how people are constrained by their social position, which is also consistent with the social determinants model (Dahlgren & Whitehead, 1993, cited in Bird & Whitehead, 2012) as well as the work of Marmot (2010) and Wilkinson & Pickett (2010).

The participants from this study talked about having mental health problems and some mention that living on a low income increased this problem by making them feel more depressed and increased the feeling of anxiety, particularly about the future. In this regard Underlid’s (2005a-b, 2012) findings are supported in this study in that participants in both studies experienced the same feelings of insecurity, especially when describing not being able to make real choices and in their experiences of meetings with NAV during which they experienced feelings of loss of autonomy. This last point suggests that the welfare state system in Norway although financially supporting people is experienced as part of the same problem of constraining their everyday lives.

6.4 Public health policy and practice implications

Even though in Norway there is a large welfare state that is assumed to support all Norwegian citizens to have a reasonable standard of living in line with the obligations of the constitution. In the last Folkehelsemelding (Helse og omsorgsdepartement, 2015) it is stated that the government will work to emphasize social factors that affect health combined with measures to limit social consequences of disease. They will also work to reduce social differences in health as well as correct measures against the underlying factors that affect the life situation (for example correct measures against things that make it difficult to quit smoking). Public health work tends to be about informing and educating people, and then assumes people will choose the 'right' (in other words, healthy) choice. However, the findings presented in this thesis indicates that people often do know, what they should and could do to maintain their health, but are in a position in life where it is very hard for them to succeed in bringing about changes because of the circumstances in which they live, which is also influenced by their level of income. Therefore, it is important in public health work to give people in these kinds of circumstances the help they need, such as support and understanding, time to listen and meet them where they are, and try to find out what are their individual needs. Given that all the participants in this study were involved with NAV, and that core aspects of the welfare state are organized through them, better ways of supporting people living on a low income is relevant to their processes and procedures, in the way they meet, help and support the people they meet on low income. The welfare system Norway has to day is in many ways unique and widely regarded as good, because it helps a lot of people who struggle, but it does have a lot of potential to improve with regard to this particular group.

It is also important that those working at NAV who met with people on low income are not judgmental and do not 'blame the victim'. In this regard, it is helpful to have an

understanding of how people's choices are constrained in a very real way by their circumstances (Hvinden, 2002). Also, policy-makers seem to accept that social inequalities are inevitable or becoming common, and that having people living on low income (which seems to be increasing in Norway as elsewhere) contributes to poor population health. Therefore, there needs to be recognition among policy makers that having people living on low income is a public health issue. However, how to address this is a complex problem. In other words, it requires a structural solution (according to Cockerham's model).

6.5 Limitations and suggestions for further work

This small-scale research project had a number of limitations. First, although qualitative research is usually based on relatively small samples, this sample was particularly small in this project with only six people agreeing to participate, all from a small geographic area and with only one man in the sample. Although in this small sample it was possible to identify patterns in the data and provide valid findings that say something about the reality of people's lives, it may be the case that if more people had been included from a wider variety of social positions and geographical locations additional themes might have emerged as well as more detailed and more nuanced understanding of the phenomenon developed. For example, the consequence of living on a low income might vary depending on whether a person is living in a city or in a more rural location. Similarly, the experience may be different for men compared to women, older and younger people as well as people from different ethnicities.

As outlined in the methodology chapter, a number of attempts were made to recruit a lager sample, but were not successful. It may be the case that potential participants were reluctant to become involved in this research because of the sensitivity of the subject, mental health issues, lack of confidence, fear of consequences and so on. With regard to the

sampling method, the researcher had little control over who the participants were and their background. They were recruited through organizations who helped and supported people with low income. Neither did the researcher have any information beforehand about their financial situation, which could mean that people actually did not meet the requirements for the study. Nonetheless, it seems that this method did recruit participants who were living on low income (because of how they described their situation and lives) and therefore met the requirements of the study.

Second, although a detailed interview guide was developed and pilot interviews were carried out, it was difficult to keep the interview on track. They thus became very long (the longest being three hours and 45 minutes), and in the end, some of the participants struggled to keep concentration and answer the last questions. This meant that some of the last answers were short and not as detailed as perhaps they could have been. These answers mainly related to how the participants viewed the Norwegian health system, and did not particularly influence the findings. This was largely down to the interviewer's lack of skill in trying to keep answers focused in an acceptable and polite way. On the positive side, it seemed that the interviewer was able to develop rapport with participants, which enabled them to feel sufficiently comfortable with her to talk about their lives. The long interviews generated a lot of data to be transcribed and analysed, and even though the researcher has conducted the analysis as carefully as she could, she is aware that some patterns and themes could have been overlooked. The amount of data could also have contributed to it becoming more difficult to "select" the most relevant data material (during the coding and categorization) given that the researcher is not an experienced researcher. The researcher also became aware when transcribing and analyzing that she could have asked more follow-up questions (probes) in order to generate even more detailed data and further clarification of particular points. However, a strength with qualitative research is the flexibility it gives the researcher

during the research process, where there is opportunity to change the interview guide and the research question (Bryman, 2012). The interview guide was changed after piloting and after the two first interviews to try to make the interview time shorter and the guide more to the point.

The topic and the themes presented in this research are very personal and private and can be difficult to talk about. It can make the participants upset, sad and angry. Even though participation was voluntary, some topics could be difficult and hard to talk about, and the participants could hold back information that could have been important for understanding how they live on a low income and make health choices. The researcher experienced one participant not wanting to talk more about her financial difficulties for instance, and one participant cried several times during the interview. All the interviews, transcription and analyses were done in Norwegian. Therefore, all the quotations were translated into English when presented in this master thesis. Because of this some of the meaning in the quotations might have been lost.

Qualitative research is often criticized for being too impressionistic and subjective and there are arguments that the findings rely too much on the researcher views of what he believes is significant and important. The aim of qualitative research is to reveal the subjective experiences and views of participants, whilst at the same time the researcher is required to" hear" what the participants are saying and control their own subjectivity. Some also argues that the response of the participants is likely to be affected by the characteristics of the researcher, and because of the unstructured nature of qualitative data, interpretation will be influenced by the subjective propensities the researcher has (Bryman, 2012). By being aware of these challenges the researcher did her best to be detached, not to influence the participants by, for example, asking leading questions. The researcher has also throughout the project been reflective over her pre-understandings and tried to have an open

and detached mind as possible under the project. There have been discussions with supervisor and other Masters students during the project which have supported this approach. The method of coding data was also important in increasing the validity of the study as it kept the researcher very much in contact with the participants' voices such that categories that were developed were firmly anchored in their way of understanding their everyday circumstances.

It is argued that it is impossible to generalize (transfer) the findings in qualitative research to other settings. However, as mentioned before in Chapter 4, people who are interviewed are not meant to represent a population in the statistical sense (Bryman, 2012). The strengths of a small-scale study are that it can reveal the world from the point of view of the participants and if the analysis is done well, it can generate a theoretical account that might have applicability to other similar situations. It is in this sense that the research project findings can contribute to more knowledge and understanding about people living on a low income and their everyday life. There can be drawn comparisons with other similar groups and/or findings and can therefore contribute to knowledge and understanding to other similar situations and/or groups.

If the researcher were to repeat this study the sampling strategy would be more direct, meaning the researcher would deliver information about the study in person, and hopefully avoid some uncertainty that she experienced during the recruitment of this project. The researcher would also reduce the number of questions in the interview guide and have more than two pilot interviews. This would allow her to develop her interview technique as well as improve the questions and try to make the interview more focused and thus not so long.

Further work might also include more men in the study and also people with differing ethnicity and from different geographical locations. This would address some of the

limitations identified above in relation to the lack of diversity in the sample. Future work might also explore what kind of support they are in need of, and in how can public health workers and the state help them in the best way. On the basis of the findings from this study the researcher has the perception that what these people actually need is not met in a satisfying way, in that they express the need for more support and understanding.

6.6 Conclusion

The findings of this small-scale study viewed through Cockerhams health lifestyle theory give an understanding that the chances and choices these people, the participants (and others in the same shoes) have limited opportunities and the hardship they feel for change is real. As they say, and Cockerham explains, it is a vicious circle, and to get out of this problematic situation they need help, but at the moment this help is hard to find. The choices people make are shaped and influenced by their social position. Poverty shapes and influence these peoples' health because it constraints them in so many ways and the choices they make are often not what they actually want, but they are not able to choose differently. In these circumstances, 'making the healthy choice the easy choice' (WHO, 1996) requires change at the structural level, not (only) the individual level. What this study may add to the research literature is the clear and unambiguous findings of the participants feeling isolated and trapped in a vicious circle.

This research has contributed to a more detailed and border understanding of how people with low income feel isolated, both by having a limited social network, and that their low income contributes and worsens this feeling. This research also highlights the health affect a pet can have to these people even thought it might constrain their financial situation further. The findings regarding the vicious circle also give a broader and more detailed understanding how low income contributes to the poor health being maintained, in the way

participants describe they do not manage to make changes by themselves and that the physical interact with mental health as well the other way round.

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Appendix 1: Interview guide – in Norwegian

«Hvordan former lav inntekt menneskers hverdagsvalg relatert til helse»

Bakgrunnsinformasjon:

- Hvor kommer du fra
- Kjønn
- Alder
- Sivilstand
- Utdanning/skolegang/opplæring
- Arbeidssituasjon/lønnetarbeid/NAV
- Husholdning – hvor mange personer, barn – alder
- Bolig / boforhold

Frivillig organisasjon:

Kan du fortelle om hvordan og hvorfor du tok kontakt med ...?

Kan du si noe om hvilken betydning … har for deg?

- Hvordan hjelper det å få hjelp fra dem?
- Hva gjør det med hverdagen din?

*Kan du si noe om hvordan du har blitt møtt?

Tror du kontakten med … har noe i si for helsa di?

- I så fall kan du forklare på hvilken måte?
- Kan du gi eksempler?
- Kan du utdype?
- På hvilken måte?

Oppsummering:

- Jeg forstår det som
- Forstår jeg det riktig ved at
- Mener du

Din hverdag:

Kan du beskrive hverdagen din, fra du står opp til du legger deg (så detaljert som mulig)?

Du har fortalt om en typisk hverdag, hvordan er en vanlig uke, inkludert helgedagene i ditt liv?

- Hva gjør du vanligvis – aktiviteter, gjøremål, sosiale møter/hendelser, handling av mat hva spiser du, huslige sysler, arbeid, etc?

- Kan du utdype
- Forklare
- På hvilken måte mener du
- Eksempler

Oppsummering:

- Jeg forstår det slik at
- Jeg oppfatter

Dine hverdagsvalg:

Kan du fortelle om hvordan den økonomiske situasjon din er i dag?

Kan du si noe om hva (hvordan) du prioriterer å bruke pengene dine på?

- Er det noe du må bort prioritere?

*Tenker du på helsegevinst eller helseskade når du gjør prioriteringer?

Hvordan påvirker den økonomiske situasjonen hverdagsvalgene dine?

- Hva du bruker penger på? Hva du ikke kan bruke penger på?
- I forhold til materielle goder, utgifter som må betales, deltagelse i det sosiale liv, kino, middag, lunsj til barna, bursdag, selskap, mat, klær, aktiviteter, fornøyelser, etc?

*Kan du si noe om hvor viktig eller lite viktig hverdagsvalgene dine er for deg? (Hvor stor/liten betydning har de?)

Føler du at den økonomiske situasjonen din noen ganger begrenser det sosiale livet ditt?

- Middagsbesøk, gjester, kino, teater, konsert, andre ting?

Får du betalt faste utgifter som telefon, lån, regninger til fristen?

- Hvilke velger du eventuelt å prioritere? Hvorfor?

Tenker du at den økonomiske situasjonen din har noe å si for helsa di? (påvirker)

*Kan du si noe om hvorvidt du synes valgene / mulighetene dine er kun opp til deg selv eller om de blir påvirket av ytrefaktorer?

- Kan du utdype
- Forklare
- På hvilken måte mener du
- Eksempler

Oppsummering:

- Jeg forstår det slik
- Har jeg forstått det riktig
- Det su sier er

Helse og livskvalitet:

Kan du fortelle meg litt om hvordan du opplever helsa di, både fysisk og psykisk?

Hva legger du i helse?

Hva betyr helse for deg?

Hva påvirker helsa di?

*Kan du si noe om i hvor stor grad helse er viktig for deg på generelt grunnlag?

*Hva teker du når jeg sier adferd som påvirker helsa di?

- Trening, fysisk aktivitet, ute, inne

- Mat, måltider
- Røyking, alkohol
- Sosialt samvær
- Tenker du at det påvirker helsa di på noen måte?

*Hva med helse relatert aktivitet

- Hygiene, egen, miljøet rundt deg
- Søvn
- Se på tv

Opplever du å ha god livskvalitet?

Hva mener du gir deg god livskvalitet?

Er det andre ting du tror vil kunne gi deg bedre livskvalitet?

- Kan du utdype
- Eksempler
- Kan du si noe mer om

Oppsummering:

- Forstår jeg deg riktig
- Er det riktig å si at

Helse forståelse:

Kan du fortelle noe om hvordan du føler det er å være i situasjonen du er i nå?

Kan du si noe om hvordan du ser på fremtiden?

- Har du noe syn på løsninger for å komme ut av den vanskelige økonomiske situasjonen?
- Ser du for deg noen måter du kan gjøre det på?

Kan du fortelle om det er noe eller noen som motiverer deg til å ta så sunne valg som mulig i hverdagen?

Kan du fortelle noe om hvilke tanker og meninger du har om bruk av helsesystemer i Norge?

- lege, tannlege, sykehus?
- Har du noen mening om du bruker de mye eller lite?
- Har du noen meninger om hvor vidt en lege har noen betydning for din helse?

- Hvilke / Hvorfor
- Eksempler
- Kan du utdype
- Forklare

Oppsummering:

- Forstår jeg det riktig
- Er det slik du mener

Avslutning:

*Før vi avslutter helt er du noe mer du ønsker å fortelle om deg selv?

- Interesser
- Bakgrunn /oppvekst /sosial bakgrunn
- Nærområde /nabolag
- Etnisitet
- Økonomi (arbeid, midler fra staten, NAV, annet?)

Er det noe du føler du ikke har fått sagt, som du ønsker å si? (relatert til temaene)

Er det noe du ønsker å utdype?

Tusen takk for din tid og samarbeid. Det har vært til stor hjelp!

Appendix 2: approval from NSD - in Norwegian

Miranda Thurston
Institutt for idrett og aktiv livsstil Høgskolen i Hedmark, campus Elverum
Postboks 400
2418 ELVERUM

Vår dato: 06.01.2017 Vår ref: 51265 / 3 / AH Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 24.11.2016. Meldingen gjelder prosjektet:

51265	*Understanding the relationship between poverty and lifestyle: a qualitative study of people living in Hedmark, Norway*
Behandlingsansvarlig	*Høgskolen i Hedmark, ved institusjonens øverste leder*
Daglig ansvarlig	*Miranda Thurston*
Student	*Anne Knippa*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 30.06.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Åsne Halskau

Kontaktperson: Åsne Halskau tlf: 55 58 21 88

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

NSD – Norsk senter for forskningsdata AS Harald Hårfagres gate 29 Tel: +47-55 58 21 17 nsd@nsd.no Org.nr. 985 321 884
NSD – Norwegian Centre for Research Data NO-5007 Bergen, NORWAY Faks: +47-55 58 96 50 www.nsd.no

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 51265

Formålet er så se på hvordan det å leve med lav inntekt påvirker personers valg i hverdagen i forhold til helse.

Utvalget består av personer med lav inntekt som benytter frivillige organisasjoner. Førstegangskontakt og rekruttering foregår via de frivillige organisasjonene. Personvernombudet legger til grunn at taushetsplikten ikke er til hinder for førstegangskontakt og rekruttering. Vi anbefaler også at frivilligheten understrekes ved rekruttering, for eksempel ved å informere potensielle deltakere om at det ikke vil påvirke deres tilbud/hjelp fra organisasjonen dersom de velger å ikke delta, samt de dem betenkningstid.

Utvalget informeres skriftlig og muntlig om prosjektet og samtykker til deltakelse. Informasjonsskrivet er godt utformet.

Det behandles sensitive personopplysninger om helseforhold.

Personvernombudet legger til grunn at forsker etterfølger Høgskolen i Hedmark sine interne rutiner for datasikkerhet. Dersom personopplysninger skal lagres på privat pc/mobile enheter, bør opplysningene krypteres tilstrekkelig.

Forventet prosjektslutt er 30.06.2017. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette digitale lyd-/bilde- og videoopptak

Appendix 3: information and consent form – English and Norwegian version

"How does living on low-income in Hedmark, Norway shape peoples' everyday choices related to health"

Information and request for participation in the research project

Hi
My name is Anne Knippa and I'm a nurse. I am currently continuing my education by working on my master in public health science, with an emphasis on lifestyle changes at Hedmark University Applied Sciences. As a part of this master project I need to do a research project. The aim of this master project is to gain an understanding of how people living on a low income in Hedmark make everyday choices related to health are made.

To gain knowledge and understanding about this, I wish to talk to people who have experience of living on a low income, whether it has been over a short or longer period of time. If you agree to participate in my research project I would like to do an interview with you, that will take approximately 60 minutes. I would also like to tape record the interview. In the interview, I will first gather some background information about you (for example, your age, education background, where you live, and so on). Then I will ask some questions about your everyday life, in order to find out how living on a low-income affects your everyday choices related to health. It is important that you know that there are no right or wrong answers; the interview is an opportunity to hear your voice and understand your experience.

If you decide to participate, you will decide where and when the interview will take place.

The interview will be treated confidentially and any quotations used from interviewees in the final dissertation will be anonymized, using pseudonyms. My supervisor and me will be the only people who have access to the interview data. Data collected is stored on a password-protected computer and the tape recording will be kept in a locked cupboard. Your answers will not be recognizable in any publication. The study is scheduled to end in June 2017, then all the information you have provided will be deleted.

It is voluntary to participate in the study, and you may at any time withdraw without giving any reason. If you withdraw, all your information will be deleted.
If you want to participate or have any questions about the study please, contact

Anne Knippa

Tlf: 47 29 76 76 E-mail: knippa.anne@gmail.com

Studien er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS

Consent form for participation in research

I have received information about the study. I have had the opportunity to ask questions and I am willing to participate. I understand that my participation is voluntary and I may at any time withdraw without giving reason.

(Signature of project participant, date)

(Signature of interviweer, date)

Norsk versjon

«Hvordan former lav inntekt menneskers hverdagsvalg knyttet til helse»

Informasjon og Forespørsel om deltakelse i forskningsprosjektet

Hei.

Mitt navn er Anne Knippa, jeg er sykepleier som for tiden tar videreutdanning. Jeg arbeider nå med min masteroppgave i folkehelsevitenskap, med vekt på livsstilsendringer ved Høgskolen Innlandet. Som en del av denne masteroppgaven skal jeg utføre et forskningsprosjekt. Målet med forskningsprosjektet er å få forståelse for hvordan det å leve med lav inntekt former (påvirker) hverdagsvalg knyttet til helse hos mennesker i Hedmark.

For å få kunnskap og forståelse om dette ønsker jeg å prate med mennesker som har erfaring med å leve med lav inntekt, om det er over en kort eller lengere perioder i livet. Om du er villig til å delta i prosjektet ønsker jeg å intervjue deg. Intervjuet vil vare i ca. 60 minutter. Jeg ønsker å bruke båndopptaker under intervjuet. Under intervjuet ønsker jeg først å få noe bakgrunnsinformasjon om deg (som for eksempel alder, utdannelse bakgrunn, bosted og så videre). Jeg vil også spørre deg om din hverdag, om hvordan din lave inntekt former og påvirker dine hverdagsvalg knytet til helse. Det er viktig at du forstår at det ikke er finnes noen rette eller gale svar, men intervjuet er en mulighet til å høre din stemme og forstå din opplevelse.

Om du ønsker å delta vil du bestemme hvor og når intervjuet finner sted.

Intervjuet er taushetsbelagt. Ved bruk av direkte sitat i masteroppgaven vil disse være anonymisert ved bruk av falske navn. Det er kun min veileder og meg som har tilgang til data studien samler inn. Data som samles inn oppbevares på passord beskyttet pc og båndopptaket blir oppbevart i et låst skap. Dine svar vil ikke kunne være gjenkjennbare i en eventuell publikasjon. Studien skal etter planen avsluttes i juni 2017, da vil all informasjon du har gitt bli slettet.

Det er frivillig å delta i studien, og du kan når som helst trekke deg uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger du har gitt bli slettet.

Ønsker du å delta eller har spørsmål om studien, ta kontakt med

Anne Knippa
Telefon: 47 29 76 76 E-mail: knippa.anne@gmail.com

Studien er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS.

Samtykke til deltakelse i studien

Jeg har mottatt og forstått informasjonen om studien. Jeg har hatt mulighet til å stille spørsmål og jeg er villig til å delta. Jeg forstår at deltagelsen er frivillig og at jeg når som helst kan trekke meg uten å oppgi noen årsak.

(Signert av studiedeltager, dato)

(Signert av intervjuer, dato)