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SOCIOLOGY AND METHODOLOGY OF SOCIAL RESEARCH- 30th cohort

Children's matters: Negotiating Illness in Everyday Interactions
at Home and School in Ghana

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Dedicated to Mary Naah

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1

The context and focus of the study

1.1 Introduction

'For a child to make a successful claim on sickness was a difficult and generally lengthy process. Most bids for the status [of] sick by children are rebuffed and to be successful children had to be determined and persistent. The only exception to this was found when very dramatic, threatening and especially visible symptoms were present. ...In order to be labelled sick the form teacher had in most cases to be convinced that the child's symptoms were real and that made it difficult or impossible to continue working in the classroom' (Prout, 1986:121-122).

The above quote is from a study of how children's claims of sickness were handled in a primary school in an English city over three decades ago. The study shows that adults questioned the competence of a child claiming to be ill. The child's subjective experiences of his or her own body in that sense did not matter. Rather, the opinion and discretion of the adult (teacher) took precedence. This scenario contextualizes the present study.

Notions of children as passive and incompetent beings in healthcare have altered over the years. Since the late 1980s-early 1990s, there has been increasing recognition—at least in Western societies—of children's ability to make their own healthcare decisions, depending on their age (see Doig and Burgess, 2000; Coyne, 2008; Franklin and Sloper, 2009; Moore and Kirk, 2010; Miller and Harris, 2011; Von Troil, 2013). Studies have further emerged which stress that children are active subjects in society and worthy of study in their own right (James and Prout, 1997). This notion, which emphasises the concept of child agency, has become increasingly central to child-related policies and practices as well (James and Prout, 1997).

Hutchby and Moran-Ellis (1998) refer to this trend as the 'competence paradigm'. That is, the view that children are competent social agents and so engage with and participate in social processes. They point out that the view that children are competent social agents may now be taken for granted by most childhood researchers following the 'competence paradigm' because the basic case for viewing children as competent agents no longer needs to be established. Rather,

they propose that what children's competence actually consists of, the forms it takes and the relational parameters within which it is enabled or constrained are the elements that continually need to be ascertained on an empirical level (Hutchby and Moran-Ellis, 1998:17).

Some scholars have advanced the argument that such changing views about children's agency are context-specific. The context in which it takes form and is enabled or constrained should be considered (Mayall, 1998; Christiansen, 1998; Mayall, 2015). For instance, whereas the school considered children as projects that needed to be executed in the best way possible, mothers conceptualized their children within the home as people with a drive towards independence and with a contribution to make in the social world of the family (Mayall, 1998). Further, there have been calls to not just focus on children's perspectives and agency but to place emphasis on the complexities, tensions and ambivalence that characterise children's lives across the world (Mayall, 2015).

Research focusing on children's agency in healthcare and illness has therefore been considered within the empirical circumstances of children's mundane everyday lives. These studies have specifically explored children's own views about their health and illness, focusing on specific contexts, situations and dynamics that characterise relations between children and adults within these contexts (Christensen, 1998; Mayall, 1998; Christensen, 1999; Brady, 2014; Jenkins, 2015; Martin, 2015; Reindstedt, 2015). Although exploring different aspects of health and illness, what these works have in common is the observation that children's agency is not a standard phenomenon, but is manifested in everyday situations and is constituted within ongoing negotiations in children's interactions with adults.

What then stands out is that children's agency is enacted within actual everyday lived experiences. The context and focus have however largely been Western societies where policy surrounding healthcare and childrearing differ markedly from other contexts. It is therefore imperative to explore how children's competence in their illness experiences is constituted in a context of weak healthcare policies compounded by social and cultural values that do not

prioritize children's opinions in decision-making. To what extent can children within this kind of society exert influence over their illness experience?

In this regard, children's health and illness experiences have been studied in non-Western societies, specifically within Africa, that have relied on the child agency tradition (see Geissler, et al. 2000; Geissler, et al. 2001; van Reeuwijk, 2001; Akello, 2003; Onyango-Ouma, et al. 2004; Wasike, 2007; Akello et al. 2007; Akello, 2010; van Reeuwijk, 2010; Bernays, Seeley, Rhodes and Mupambireyi, 2015). These studies show how, even in the midst of systemic shortfalls in healthcare policy, children exert agency in dealing with and making sense of their illness. Worthy of mention is also the observation of children self-diagnosing and self-medicating as a strategy to seek health (Geissler, et al., 2000; Wasike, 2007; Akello et al. 2007; Akello, 2010). These outcomes stem from the poor regulation of pharmaceutical markets within these settings (Bledsoe and Gouboud, 1988). These circumstances however raise crucial public health concerns.

Although these settings provide similar circumstances such as policy surrounding healthcare and socio-cultural values around children for a country like Ghana, the specific situations for some of these studies differ. For instance, Akello (2010) studied children in a context of war and insecurity and so this makes the situation of the children peculiar. In addition, some of the research set in Africa has largely focused on named disease categories such as fever, diarrhoea, malaria and HIV/AIDS to elicit children's views (Wasike, 2007; Akello et al., 2007; Barneys et al., 2015). How do children under a similar policy and to some extent socio-cultural context make sense of a sensation of feeling unwell (physical bodily pain, emotional and psychological distress) when there are no words to describe what they are experiencing or no diagnostic criteria to establish what they are feeling? Addressing this question may prove useful for finding out how children engage with each other and with adults to make sense of their illness and to contest the meanings associated with their subjective experiences. It will also aid an exploration of the extent to which children, in a context where their opinions are less likely to be considered, can influence decision-making through their illness situation.

Further, emphasis in the research cited above has not been specifically on how the social position of children structure child-adult interactions, which may in turn limit or facilitate children's exertion of influence over their illness circumstances. As Lareau (2002) asserts, social class, for instance, plays a crucial role in the nature and depth of relations children have with adults. It is therefore these gaps that the study seeks to address within a context, Ghana, where there is a paucity of documentation on children's own perspective in their illness experiences.

Despite the dearth of studies that specifically seek children's views on their illness experiences in Ghana, one study in this regard is worth noting - that by Hampshire, Porter, Owusu, Tanle and Abane (2011). Its focus, though, is on the health-seeking behaviour of children between the ages of eleven and eighteen, and highlights the resources that help them make these healthcare decisions. The meanings that children attach to their illness as well as how their relations with the adults they interact with either enable or restrict their ability to actively deal with their illness has not been explored, to the best of my knowledge. Meanwhile, Ghana presents a context where healthcare is emergent, pluralistic and mostly adult-centred. In addition, child-adult relations are generally perceived to be strictly hierarchical, leaving no room for children to take part in decision-making. I however lean on Giddens' (1984) assertion that culture and societal values are fluid and so relations and interactions are constantly modified, not static. Thus, this study seeks to locate where and how in interactions children in this context influence decision-making, and the scope and limits of this influence through their illness experiences.

By referring to children's competence, I draw on Christensen's (1998:188) cultural approach to the term as a relational constitution or attribution that is socially constructed and negotiated. To break this down further, competence as used in this work has more to do with children's ability to manage their social surroundings, together with the resources these give children to engage in meaningful social interactions in specific situations and contexts (Hutchby and Moran-Ellis, 1998). I therefore present competence as something children negotiate, argue about and struggle over in social relations and interactions

rather than as some specific developmental and cognitive stage children attain (Hutchby and Moran-Ellis, 1998).

1.2 The prevailing cultural, social and healthcare patterns around children in Ghana

Although Ghana is a multi-ethnic society, childhood and child-rearing practices rarely show variations across the various ethnic groups (Adu-Gyamfi, 2014). Having children is a defining characteristic of most Ghanaian families, as children are symbols of status, respect and the completeness of the family (Sossou and Yogtiba, 2008). Nukunya (2003) observes that since most Ghanaian traditional societies are organized on the basis of descent groups, the only way to ensure continuity of these groups is to have as many children as possible. Again, the strength and prestige of these groups are measured in their size. Children also provide insurance against old age. Women who have not been able to have children are pitied and in some instances are the subject of insults and humiliation, while childless men are in a no better position (Nukunya, 2003). Therefore the importance of children in this context cannot be overemphasized.

Twum-Danso (2010) identifies four key components of how childhood is conceived in Ghana. First, she notes that childhood is considered a period of dependency. That is, a person who relies on their parents for all their needs is conceived of as a child. As a dependent who relies on others for their needs, a child is restricted in the ability to express his or her views. Closely tied to the first component is the view that childhood is a period of parental control and ownership, meaning that the life of a child is considered to be in the hands of his or her parents because that child is dependent on them for his or her needs.

Thirdly, Twum-Danso makes the case that childhood is never-ending. That is, age does not determine the end of childhood. It also reflects the eternal nature of parental control and authority. In a group of adults, the youngest is considered a child no matter their age. Children have thus been observed to recreate the hierarchical relationships within the society in their own worlds, with older

children treating younger children who are not within their age group the same way the age group ahead of them treats them (Twum-Danso, 2010).

Lastly, she points out that childhood is considered a period of obedience and respect and so culturally required behaviour (respect) flows bottom up. Children are taught respect and obedience towards elders from an early age and are not supposed to challenge adults nor question what they are asked to do (Twum-Danso, 2010). They must not consider themselves superior and must submit themselves to adult control (Twum-Danso, 2009). Thus, in Twum-Danso's view, the core of what constitutes childhood in Ghana is respect and obedience. The centrality of these values to the socialization process cannot be overemphasized. These values are geared towards moulding children into responsible and respectable adults in the future (Gyekye, 1996).

In this way, those considered children are positioned at the bottom of the social ladder and are not only expected to respect adults but to remain low profile in their presence (Twum-Danso, 2010). They are not supposed to argue, debate or participate in conversations unless they are asked to and in some cases are not expected to look directly into the faces of adults (Salm and Falola, 2002; Kauda and Chacha, 1999). A child also has to choose words carefully when speaking so that the adult will not be insulted (Salm and Falola, 2002).

What is crucial here is that these expectations of children are reinforced through all forms of disciplinary action including physical punishment which both adults and children point out as justified to some extent to maintain social order (Twum-Danso, 2010). The emphasis on respect and obedience in child-rearing processes means that children may find it difficult to challenge, disagree or question adults (Twum-Danso, 2009; Boakye-Boaten, 2010; Adu-Gyamfi, 2014). This has implications for children's participation in everyday life in Ghana. Children and young people succumb to adults and so cannot challenge or disagree with decisions made by adults even when they are not in favour of such decisions.

Healthcare policy

Viewing children this way translates into the policy that surrounds children's health needs in the country. Formal health service delivery in Ghana is the responsibility of the Ghana Health Service and the Christian Health Association (Ministry Of Health [MOH], 2014). Aside from the biomedical facilities and agencies that offer healthcare services, some Ghanaians rely on what are often referred to as traditional healers as well as spiritual healers to deal with illnesses (Twumasi, 2000). In a context of medical pluralism, some Ghanaians manage their illnesses by themselves either through the use of pharmaceuticals or herbal remedies. With the Structural Adjustments Policies (SAPs) of the 1980s, trade was liberalized and this saw the commodification of medicines (Senah, 2001). In Ghana all types of pharmaceuticals can be bought without prior consultation with a professional and without a prescription. The only determinant is the individual's ability to afford the medicine (Senah, 1997).

Child health policies in Ghana largely prioritize the health needs of children below five years old and adolescents. There may be two reasons for this. Firstly, there is a high incidence of child mortality in children below the age of five, and secondly such policies meet the priorities of international donors who support healthcare in the country (UN MDG Report, 2007; Ghana MDG Report, 2010; UN MDG Report, 2013). The question that remains, however, is what happens to those above the age of five and yet below the age of adolescence? This group of children are mostly found in primary school.

Healthcare policy for this category of children is generally formulated within school health because these are children found in primary schools. School health usually pays attention to worm infestations, diarrhoea, respiratory infections, personal hygiene and adolescent reproductive health education (Owusu and Appiah, 2013; Ghana Education Service [GES], 2014). In 1992, the School Health Education Programme (SHEP) was established in collaboration with stakeholders such as the Community Water and Sanitation Agency (CWSA), Ghana Health Service (GHS) as well as international non-governmental organisations (GES, 2014). Although established with the aim of creating healthy school environments for children, its emphasis is on Water, Sanitation and Health

(WASH). It is also aimed at developing the life skills, values and knowledge of the children through the use of participatory teaching methods in the classroom (Adu-Mireku, 2003). In this way, the following health issues are required to be covered within the subject areas in the school curriculum: personal hygiene, environmental sanitation, food hygiene, water-borne diseases, adolescent sexual reproductive health, STDs, HIV/AIDS, teenage pregnancy and accidents in the home and school (Adu-Mireku, 2003).

In most schools, however, these are merely policy outlines that are hardly carried out in practice. This is because of the general idea that children above the age of five will have developed significant immunity for communicable diseases (WHO, 2008; WHO, 2009; Akello, 2010). They are therefore considered a 'healthy group'. Additionally, they are not recognised as healthcare seekers on their own but rather through the assistance and care of adults. The healthcare system can thus be largely described as adult-centred.

In a recent medium-term health plan by the Ministry of Health of Ghana (MOH), spanning 2014 to 2017, this group of children are barely mentioned. The only point at which mention is made of them specifically is in the projections for 2017 (MOH, 2014). Here, it is projected that adolescent health corners will be established in hospitals and that healthy lifestyles will be integrated into the curriculum of basic schools and teacher training colleges. However, research among primary school children in Uganda and Kenya, which have similar contexts to Ghana, show that this age group are active agents of cure and engage in self-diagnosis of illness and self-medication (Geissler et al., 2001; Akello, 2007; Wasike, 2007; Akello; 2010).

Social change

Ghanaian society is however not untouched by social change. These social changes not only have the potential to alter child-adult relations but also choices in making decisions surrounding health and illness. For instance, within the domain of health seeking, Hampshire et al. (2011) observe how the mobile phone has become a useful resource for young people seeking healthcare in Ghana and

other parts of Africa, thereby showing how health-seeking behaviour is evolving even among children who are perceived as passive in decision-making.

Moreover, there has been decline in fertility rates in a context where having children is highly prioritized (Agyei-Mensah and Aase, 1998; Agyei-Mensah, 2002). Higher literacy rates among women taking part in formal education have been shown to delay childbirth, which has consequently resulted in these women having fewer children (Oppong 2006; Therborn, 2006). Changes in family structures leading to a preference for nuclear families have also been observed (Oppong, 2006). These changes all have the potential to alter social relationships and the values that are prioritised within the society. This trend has been linked with the growing middle classes in Ghana.

According to the African Development Bank (ADB, 2011), 46% of Ghana's population belong to the middle classes. The middle classes in Africa have been observed to display certain distinct features, namely that they: are not likely to derive their income from agricultural and rural economic activities; are less likely to be farmers, land owners or manual labourers; are more likely to have salaried jobs or small businesses; tend not to rely entirely on public health services and seek more expensive medical care when ill; have fewer children than their poorer counterparts and spend more on the nutrition and schooling of their children; and are better educated and more geographically concentrated in urban areas or along the coast (ADB, 2011). These features that describe the middle classes are largely in terms of economic and income-based positions.

Spronk (2014a), writing on the middle classes of Kenya, points out that a truer measure of the phenomenon of the African middle class is socio-cultural and that societal transformations have always caused shifts in social organization, enabling new forms of consciousness and new modes of living. Thus, social change is not merely an economic transformation but also a sociocultural evolution. The middle classes can be conceived as an emerging social group in African metropolises who, though not clearly defined, are recognizable (Spronk, 2014b). They have been observed to subscribe to values that conflict with the existing norms and values of the larger society and so are ambivalent in that they

fear they do not belong to the predominant sociocultural value system, while at the same time they do not want to be a part of it (Spronk, 2014b).

The media has been recognised to play a huge role in articulating how lifestyle choices around everyday practices such as living arrangements, family, consumption patterns, and leisure become the very core of these people's identities (Spronk, 2014a). Spronk further opines that there is an emergence of a middle class culture which legitimizes lifestyle choices and work as a way of socialization for the younger generations into adulthood. In relation to this study, the argument I make is that this social group may have the potential to challenge the existing norms and values surrounding childrearing and child-adult relations as well as healthcare choices beyond the standards that exist in the country. That is, whether and how the social class a child belongs to define the nature of interactions with adults and the extent of agency it allows, specifically in relation to making meaning of and dealing with illness.

To further this argument, I outline some evidence of children's participation in a space perceived to be largely dominated by adults. Bjornsdottir (2011), for instance, observes that although children in Ghana face obstacles in decision-making mainly due to cultural hierarchy and deficiencies in government institutions, potentials exist to enhance their participation. He notes that there is a large presence of both local and international NGOs in Ghana, as in many other African countries, who work with principles and buzzwords like empowerment, participation and human rights. Within the framework of NGOs, the active involvement of local people is stressed as well as development aid principles of participation, partnership and inclusiveness of beneficiaries (Bjornsdottir, 2011). The involvement of everyone is thus emphasized, most especially people considered vulnerable, such as children, in development. Examples of some of these NGOs visibly spread throughout the country include but are not limited to UNICEF, Curious Minds, Ananse Reach Concept, Christian Children's Fund of Canada, Child Rights International, WASH Ghana, Afrikids, Widows and Orphans, Plan Ghana and World Vision Ghana.

Other evidence of children's participation is observed within the Ghanaian media. There are television programs that are hosted by children such as *New Generation* on Joy TV, a private television network in Ghana. On these programs, issues around national development, health, education, religion, morals, sport and so on are discussed by panel members who are mainly children. There is also a newspaper, the *Junior Graphic*, which is the children's version of a major newspaper in Ghana, *The Daily Graphic*, dedicated to and contributed to by children. The content is largely written by children and it features news on children's activities at school, church and sporting events. It also reports on child-centred news around the world in its foreign news section. From these instances, it can be observed that although the socio-cultural and policy climate of Ghana around children gives few opportunities for children to actively take part in decision-making concerning their life, potentials for children to do this do exist.

1.3 Scope and focus of this study

This study identifies gaps in the literature, particularly within the Ghanaian context. Although the new paradigm or new study of childhood seem to be gaining ground, only few researchers have relied on children's own perspectives on their lived experiences in Ghana (see Twum-Danso, 2009, 2010; Tetteh, 2012; Adu-Gyamfi, 2014). Within these studies, however, focus has been on child labour, child poverty, and the United Nations conventions on the rights of the child. On issues of child health and illness, the concern of research within this context has mainly been on the mortality rates of under-fives (Boadi and Kuitunen, 2005; National Development Planning Commission and UNDP Ghana, 2010; Tagoe-Darko and Gyasi, 2013; Owusu and Appiah, 2013), mother's health-seeking behaviour for children under five years old (Hill, Kendall, Arthur, Kirkwood and Adjei, 2003; Adjei, Darkwa, Goka and Bart Plange, 2009), and common tropical diseases that affect children (Binka et al., 1996; Biritwum, Welbeck and Barnish, 2000; Mockenhaupt et al., 2004; Ahorlu, Koram, Seakey and Weiss, 2009; Adjei et al. 2009).

In addition, healthcare policy and socio-cultural values concerning children differ markedly from most Western societies. In the first place, there is no comprehensive health policy targeting children above five years (mostly found in primary school) and children are usually treated as passive recipients of treatment, making the healthcare system predominantly adult-centred. This situation is compounded by socio-cultural values that emphasize a hierarchical relationship between children and adults. Given this background, this study pursues an ethnography in two primary schools in Ghana where the perspectives of the children on their illness experience are sought. The focus is on how children's complaints of feeling unwell are dealt with in the mundane interactions between children and adults at home and school.

In considering the illness experiences of primary school children as the focal point of the study, I am guided by Mayall's assertion that researching children's health and illness experiences functions as a lens through which the dynamics of children's relations and interactions with adults within society can be grasped (Mayall, 1998). Also one of the tasks of sociology is to relate the biological to the social order, and in studying illness behaviour, particularly that of children, the subject matter of the study lies rightfully within the domain of sociology (Freund, 1990). Moreover, most health research involving children in developing countries, and Ghana in particular, focuses on known diseases and treatments as well as on the declining rates of some tropical diseases among children (see for instance Ewusie et al., 2014). This is necessary as it gives an opportunity to understand disease patterns and the existing structural provisions that aid or constrain how these diseases are dealt with. This study, however, departs from this trend to consider a quite uncharted area: the views of children themselves concerning their illness experiences in interactive encounters with adults, how this process is constituted and the extent to which children are allowed to participate in and to influence decisions in this regard.

In paying particular attention to undiagnosed sensations of feeling unwell, the concerns of medicalization come to the fore; that is, the social process by which personal troubles and needs are translated into medical terms and treated by medical experts (Emerson and Messinger, 1977; Conrad and Schneider, 1980).

Research surrounding medicalization has often looked at situations where medicalization has already been resorted to, but what is its relevance beyond the boundaries of health institutions and professionals? It has for instance been shown that people use medicalization, dismiss it or contest it to deal with disruptions in their daily life (see Bröer and Bessling, 2017). Relying on everyday interactions and processes between children and adults around illness opens up the opportunity to explore medicalization outside of the clinical realm. In doing this, it becomes imperative to interrogate to what extent the prevailing social institutions and biomedical establishments drive medicalization in the context of the study. The extent to which existing social discourses and medical knowledge surrounding illness are drawn upon to explain disruptions in daily life as well as the role of these discourses in shaping the conceptualization of not feeling well must be explored. In addition, there is the need to find out the ways in which these discourses are used, resisted and contested through interactions and relations between children and adults in attaching meanings to children's complaints. This is necessary as it has been argued that medicalization is a process that can be sought by both professionals and non-professionals, and that can be resisted or challenged (Clark, 2014; Ballard and Elston, 2005; Conrad, 2005). The study thus inquires the usefulness of this theory to explain the conceptualization of illness experiences that have not yet been medically categorised in a context where medicalization may be less pronounced than in the Western context, for instance, where medicalization theory originally developed. This approach may stir and contribute to discussions about the growth of the medical institution in relation to everyday needs.

In addition, the everyday illness experiences of Ghanaian children are prioritized in the spaces of the home and school. Hutchby and Moran-Ellis (1998) propose that in researching children's social competence, the focus should be on what they call children's 'arenas of action'. These arenas of action include the priorities of politics and policy-making which structure the institutionalized worlds of childhood and the nature of children's relationships with each other and with adults in the social spaces in which they live (Hutchby and Moran-Ellis, 1998: 16). They also state that the idea that children are competent social agents requires that researchers situate the study of those competences 'from within',

i.e. in the empirical circumstances of children's real, ordinary, everyday lives because these circumstances can both be enabling and constraining in terms of children's capacity to display social competences (Hutchby and Moran-Ellis, 1998: 11). In line with this, I emphasize everyday interactions at home and school between children and adults and also with peers as these are the two main spaces Ghanaian primary school children spend their time. These are also the spaces that reflect the prescriptive and structural patterns of interactions of the larger society or the 'arenas of action' of primary school children in Ghana. Thus, by looking 'from within' (home and school), relevant social action and constraints may reveal procedures by which the participants (children and adults) themselves organize and make sense of children's illness experiences within a particular social context (Hutchby and Moran-Ellis, 1998: 11). In undertaking this endeavour, I take into consideration that children differ in their upbringing, and hence the depth and nature of their experiences, interactions and perspectives (Akello, 2010; Lareau, 2011; Lareau, 2002; Scheper Hughes, 1993).

1.4 Research Question

Given the background described above, the gaps in literature highlighted and the focus of the study, the main question asked in this study is: How do children, in the context of an adult-centred, pluralistic and emergent healthcare system, negotiate their illness experiences at home and school? That is, the ongoing interactions within the society, the largely adult-centred healthcare system, the social change underway with a potential for altering what societal values are prioritised, and the taken-for-granted notion that the relationship between children and adults in Ghana is unidirectional and relatively stable are interrogated through the illness experiences of children. This is done by taking into cognizance how social transformations shape the changing experiences of childhood and their implications for children's agency and the boundaries of this agency. Again, how children's competence in their illness experiences is constituted depends on the social position of the child such as gender and social class. In addition, how children make sense of and deal with their illness experiences and how far adults facilitate or inhibit these processes is considered.

It is the study's aim that findings will not only strengthen and expand on the body of research on children's agency, especially in a context where children are perceived as less influential, but also serve as a basis for policymakers to reconsider and strengthen school health policies to adequately meet the realities of primary school children in Ghana.

In order to narrow the focus and aspects of children's illness experiences, the following questions have been specifically formulated:

1. How are perceived sensations of feeling unwell actively constructed and dealt with by children in everyday interactions?
2. How does a child's social position influence the construction of and the strategies to deal with these sensations?
3. What are the circumstances under which the genuineness of a child's claim of feeling unwell are resisted, modified or accepted by parents and teachers?
4. What and how are medical categories and treatments used by children and adults to frame a child's sensation of feeling unwell?

1.5 Significance of the study

As indicated earlier, health research in Ghana has mainly focused on the perspectives of adults even when children are involved. Health research in this setting has also mainly relied on existing disease categories. This study departs from these trends to engage children directly in research and by focusing on undiagnosed health complaints, offering an alternative view on children's illness which leads to an essential expansion on the health and illness literature in Ghana. The findings of the study also have the potential to be integrated into policy initiatives and interventions surrounding health care for Ghanaian children above the age of five.

Children's views about illness draw attention to medicalization and the use of pharmaceuticals. They thus open up discussions and opportunities for further research into the medicalization of everyday needs and routines by non-

professionals in a context where access to medical treatment is limited and the institution of medicine is less dominant. The findings also make an essential contribution to the body of work on medicalization by providing insights from the less powerful (children) in society as consumers, rather than the usual focus on patients who have already encountered a doctor, the state, health professionals and pharmaceutical corporations.

In emphasising the social position (gender and social class) of children, the study specifically shows how this plays a role in structuring relations and interactions around illness in the Ghanaian context. It proves useful in a society where the general perceived notion of relations between children and adults is considered hierarchical. The study draws attention to new dimensions to be considered in child-adult interactions in this setting such as the power position of parents. The study therefore points out alternative considerations including gender and social class in conceptualizing child-adult relations in Ghana and similar contexts.

In addition, this study contributes to research that follows the tradition of viewing children as social agents who are capable of influencing their own lives. This is done by showing ways in which children, in a society in which they are less likely to be involved in decision-making, manoeuvre the tensions in interactions with adults, and strategize and engage with their social surroundings to deal with their illness. The study therefore evidences and furthers the position of scholars in the child agency tradition to focus on the specific contexts and situations of children's lived experiences as a way to grasp fully the social life of children.

1.6 An outline of the thesis

Chapter one: This chapter sets the scene for the study. The background to the study, the scope and focus of the study, the research questions, the significance of the study and this outline of the organisation of the thesis have all featured here.

Chapter two: In this chapter, previous works that have focused on children's illness experiences from their own perspectives are engaged. This is done with a focus on the different contexts (Western and non-Western) in which they were carried out. The chapter is organised around children's sense making and conceptualization of feeling unwell, how children deal with not feeling well, the social position of children and how this either aids or hinders their participation in decision-making on their illness experience, and the ways in which children and adults negotiate ill health experiences through interactions. The gaps in these works that the study addresses are also identified. Further, the theoretical concepts that help to bring together the different strands of the study are articulated here.

Chapter 3: The social and physical space in which the study is situated is detailed in this chapter. That is, the geographical location and physical environment of the two primary schools selected for the study. The social actors within these physical and social spaces are also introduced to enable familiarity with the social and physical context of the study sites.

Chapter four: A detailed outline of the research orientation and processes involved in selecting the research field and collecting data is the focus of this chapter. The research methods, the process of the fieldwork and the techniques employed in collecting data are described. In addition to the data analysis procedure, the ethical issues encountered and a reflection on the overall process is documented in this chapter.

Chapter five: This is the first analysis chapter of the thesis, addressing the first research question. It focuses on how children actively construct and deal with

their illness. As much as possible it features only the perspective of children in making sense of and dealing with not feeling well.

Chapter six: The second research question is addressed in this chapter. It focuses on the social position of children, and the nature and depth of relations and interactions this enables in dealing with feeling unwell. It also outlines and discusses the social connections that children rely on when they do not feel well and why children resort to these connections.

Chapter seven: Ways in which children's illness complaints are accepted, refined or rejected is the main focus of this chapter. This highlights the views children and adults (mothers) hold about themselves and how this translates into the ways illness complaints are handled. The tensions and negotiations between children and mothers over illness complaints are also detailed.

Chapter 8: The different ways in which children and adults conceptualize and frame illness complaints are discussed here. The reliance of children on medical categories and adults on stress resulting from social obligations, problems at home and lifestyle patterns are shown. These varying views have implications for the treatment patterns and options resorted to in dealing with children's illness complaints.

Chapter 9: This is the final chapter of the thesis. It summarises the findings in the study in relation to the research questions, literature engaged and the theoretical framework used. Where necessary, research and practice implications are shown.

2

Literature review and theoretical framework

2.1 Introduction

This chapter engages the available literature on children's agency in making sense of and dealing with illness. It also reveals the gaps in literature the study seeks to address and puts the study into perspective. I discuss the literature, focusing specifically on existing works on children's sense-making and conceptualization of feeling unwell, how children deal with not feeling well, the social position of children and how this either aids or hinders their agency in making sense of and dealing with their illness experience, as well as the ways in which children and adults negotiate ill health experiences through interactions. In addition, the theoretical framework in which the study is situated is articulated.

2.2 Review of the relevant literature

Ethnographic work that focuses more specifically on investigating children's agency in their illness experiences shows that children can no longer be comprehended as passive recipients but must also be seen as active participants in health care (Christensen, 1998). To begin with, two pioneering studies—Bluebond-Langner (1978) and Prout (1986)—on children's involvement in everyday negotiations of sickness are worth noting. These studies indicate ways in which children make sense of feeling unwell. Although these studies were conducted decades ago, they remain relevant in setting the tone to begin to look at ways in which children's competence regarding their illness is constituted in everyday interactions.

Against the backdrop of several scholars presenting children as passive and unable to understand their illness condition, Bluebond-Langner (1978) shows through an ethnographic study of children with leukaemia that children are wilful, purposeful individuals who are capable of creating their own world and not merely passive internalizers of norms and values (1978:7). This study discusses ways in which children make sense not only of their illness but also become aware of their impending death because of the illness. Children in the study are observed to be capable of this through their interaction with other children suffering from the same ailment. They also read clues off pharmaceuticals,

the types of treatments they undergo at every stage of the illness and adult's behaviour towards them (Bluebond-Langner, 1978). These sources aided the children in conceptualizing their illness and also gauging how long they had to live even though health personnel and parents thought they had shielded the children from this information. Although Bluebond-Langner's study focused on children who had already encountered a health care professional and received a diagnosis, it is useful for this study as a starting point to examine how children make sense of their illness in a situation where there is no name yet to describe what they are feeling.

Prout (1986) focused on primary school children who merely had health complaints and had not yet encountered a health professional, in a small community in England. These children made complaints to either their teachers or parents depending on whether they were at home or school. The child's illness claims could either earn the child a school sickness absence or not, depending on whether parents and teachers accepted the children's claims. The study observed that children's informal interaction such as persistent claims of illness or feigning symptoms had a significant influence in successfully claiming illness even though they had no formal power in decision-making (Prout, 1986).

Since the inception of these earlier studies, several studies have sprung up that attempt to show how children make sense of not feeling well. For instance, children's awareness of their body have been linked with ways in which children make sense of not feeling well. Mayall (2015), building on her previous theoretical and empirical research on the status of child health in sociological research (see Mayall, 1993, 1998), points out how ideas about the body structure children's experience of their body and emotions. The consciousness of children about their body is a way for them to make sense of how it works and what it is capable of. They are thus able to make sense of what is going on with their bodies. Although focusing on health and wellbeing rather than illness, her analysis highlights that children are social actors acting with, through and for their bodies (Mayall, 2015).

Closely linked with this, Christensen (1999) observes that children's learning about illness is a complex interpretive process. Using an ethnographic study with six to twelve year olds, she identifies three aspects of this interpretive process:

Learning to distinguish illness from other events in the flow of everyday life; exploring their body and combining subjective experiences of it with cultural models given by adults; accomplishing this both as individuals and collectively with other children (Christensen, 1999: 39).

That is, children are actively involved in exploring and understanding their body. This proves useful in dealing with illness complaints in social interactions around everyday illness (Christensen, 1999).

Similarly, in a study of obesity among children, Martin (2015) observes that the child's body is both biologically and socially constructed. Socially, the child's body is rooted in and co-constructed through shared beliefs and values. Children draw on these values to depict their own bodies as fat or not. They also perceive themselves as different and develop their own private coping strategies to manage the levels of exclusion they often feel because they look different (Martin, 2015). Thus, children draw on the experiences and knowledge of social expectations through everyday interactions to consider how they feel as either normal or not.

Children's ideas and understandings of illness have also been explored on the African continent. Akello (2010) and Wasike (2007), studying Ugandan children, observe that children rely on physical signs and symptoms as a way of knowing that they are unwell. These signs include headache, stomach ache, vomiting, high body temperature and feeling cold. The children also relate illness with being unable to do their normal everyday activities. Further, the children relate these symptoms with existing disease categories such as malaria, diarrhoea, skin infections, flu, typhoid or fever (Akello, 2010; Akello et al. 2007; Wasike, 2007). These studies show that the children were able to self-diagnose based on information accumulated through interactions with peers, family members, teachers, the church and the media.

Several studies have also explored children's perceptions and conceptualization of illness and health using interviews, drawings and essays (see Mouratidi, Bonoti and Leondari, 2015; Piko and Bak, 2006; Buchanan-Barrow, Barrett and Bati, 2003; Schmidt and Frohling, 1999; Charman and Chandiramani, 1995; Springer and Ruckel, 1992; Campbell, 1975). However, many of these studies have taken a developmental approach such as the consideration of the age of the children and how this influences their conceptions of health and illness (Campbell, 1975; Buchanan-Barrow et al., 2003; Piko and Bak, 2006; Mouratidi et al., 2015). For instance, children aged eight to eleven years old have been shown to express both a biomedical and holistic approach to health (Piko and Bak, 2006: 651). Older children have also been observed to produce more multifaceted depictions of illness and health than their younger counterparts who mainly rely on biomedical depictions (Mouratidi et al., 2015: 7). However, compared with adults, children were more likely to link illness with medical procedures and biological functions than adults who perceive it in more psychosocial terms (Mouratidi et al., 2015: 11). It has further been indicated that children's understanding of and conception of illness is based on their past personal experiences and knowledge of biomedical health concepts (Charman and Chandiramani, 1995; Buchanan-Barrow et al., 2003; Piko and Bak, 2006).

Within a non-Western context, Van Reeuwik (2001) studied children's understandings and practices concerning dirt, hygiene and disease transmission, through observations and conversations with children in rural Benin. She highlights ways in which children conceptualize and make use of hygiene practices that may or may not expose them to the risk of diarrhoea and other gastrointestinal diseases. Thus children within this context also view and relate illness with biological causing agents such as germs within their environment. This study makes a case for the relevance of policymakers to have knowledge about children's ideas concerning disease causation and transmission in order to strengthen public health education.

Wasike (2007) observed that in addition to biological attributes given to having a fever, children also made references to non-natural attributes such as coming into contact with 'bad winds' while fetching firewood in the bush at night. This

goes to show how children acquire and reflect the complex socio-cultural concepts of illness. Similarly, children relate the psychological categories of ailments with supernatural factors within their environment (Akello, 2010).

It is worth mentioning that the studies outlined in relation to how children conceptualize and frame illnesses largely made use of existing disease categories. These disease categories include chicken pox, asthma, diarrhoea and AIDS. This present study departs from this trend to rely on children's vague complaints and claims of feeling unwell to make sense of what and how children frame illness.

Beyond making sense of and conceptualizing their illness experiences, children have also been observed to take an active role in devising strategies to deal with their illnesses. Wasike (2007) identifies four strategies that children employ in dealing with fever: self-diagnosis, deciding to communicate what they are feeling to adults, negotiating with adults, and seeking treatment (Wasike, 2007: 48). Of the four strategies, he points out that self-diagnosis usually initiates health-seeking within the home. Children make decisions and communicate their experience to adults through suggestions of their inability to take part in normal daily social activities that they are expected to participate in. Once this is done they have to further negotiate with adults through pragmatic ways to convince them about the necessity to take action to deal with the fever. However, when negotiation fails, children devise their own health-seeking strategies.

In a context of war, with limited focus on healthcare planning, and a lack of services, Akello (2010) highlights ways in which children in Uganda dealt with their illness and the coping strategies they developed in the midst of systemic failures. These included buying medicines from the local drug stores, visiting health facilities and using herbal remedies. The study draws attention to the prioritization of the health needs of children above five years old.

In the same way, it has been shown that children in Africa commonly use medicines to deal with illness (Geissler, et al., 2000; Geissler, et al., 2001; Akello 2003; Onyango-Ouma, et al., 2004; Wasike, 2007; Akello et al., 2007; Hampshire

et al., 2011). Children have various sources including friends, the home and the school canteen for accessing medicines (Akello, et al 2007), largely due to the commodification of pharmaceuticals in these settings. This is in line with Bledsoe and Gouboud's (1988) observations that medicines within this context are as available as Coca-Cola. Also among medicines used by children in these studies, painkillers such as paracetamol, antimalarials and in some instances antibiotics have been identified as commonly used (Geissler et al. 2000; Akello et al., 2007; Akello, 2010; Hampshire et al., 2011). It is also noted that children made use of herbs advertised on the radio as well as herbs prepared at home to treat their symptoms (Akello, 2010; Hampshire et al., 2011).

Besides the use of medications, children have also been indicated to use unusual means to cope with and to treat their illness. Bernays et al. (2015) explored children as health actors through the illness narratives of children living with HIV and accessing anti-retroviral treatment (ART) in Uganda and Zimbabwe. These narratives reveal a complex picture of illness stories and the resistance to being defined as ill. The researchers identify what they refer to as 'protest talks', which are used by the children to come to terms with the ambiguities of being considered sick while looking and feeling well. This study is useful as it points out the challenges that come with long-term treatment for illness. It also highlights unconventional ways through which children cope and deal with illness.

Further, the ways in which children deal with their illness experiences—in terms of their decision-making, and the availability of and access to resources to deal with illness—have been shown to be influenced by their social position. Gender has also been identified as a factor that influences decision-making and access to resources to deal with illness (Wasike, 2007; Geissler, et al., 2000). Wasike (2007) argues that unlike girls, boys' abilities to act on their illness (fever) is enhanced by their special social relations with their fathers. This relationship brings with it privileges such as getting money from their fathers which they could use to buy medicines for any episode of fever. Thus, boys' social position within the family and easy access to the father who is often the breadwinner

gives them resources and wider choices to make in illness experiences which girls did not have (Wasike, 2007).

Hampshire et al. (2011) also found among young Ghanaian children that age made a difference in the resources available to seek health. Older children, they state, have more freedom, less parental control and assume more adult roles, and so have money to access different avenues for treatment than younger children. Within this study, it was also noted that a child's high educational status gave him or her an edge over those without an education in terms of access to especially formal facilities to seek health care. It is pointed out that education improves the use of the English language, which is largely the language of communication to interact with health professionals. Further, the study observes that the geographical location of a child influences how illness is dealt with. Children living in urban areas are more likely to make use of hospitals than those living in rural areas due to their relative proximity. Rural counterparts are more likely to purchase over-the-counter medicines (Hampshire et al., 2011).

Money has also been recognised as a resource that influences children's quest to deal with illness. On the one hand, Akello (2010) notes that the type and quantity of medicines given to children buying medicines at a local drug store depends on the amount of money the children have. Hampshire et al. (2011) note that children who engage in extra activities such as manual labour (boys) and petty trading (girls) as well as those who receive lunch money from their parents are better positioned to make use of a variety of services when confronted with dealing with their illness.

Other resources have also been identified as aiding children to deal with illness. Hampshire et al. (2011) found among the Ghanaian children they studied that those who had access to a mobile phone and the broadcast media and possessed health insurance were better placed to make several choices in ill health situations. In all such studies, however, a conscious comparison was not made between children from lower class and middle class families. Also, the existing relational criteria between children and adults and the resultant nature of interactions that this produces has not been sufficiently dealt with. This study

therefore addresses this gap. This is a necessary endeavour, as Lareau (2002) argues that some aspects of adult-child interactions, and the outcomes they produce for children's lives, are influenced by social class.

The discussion of the literature so far points to ways in which children across various social contexts make sense of and deal with illness. However it has been shown that children do not act in a vacuum and have to deal with adult intervention and scrutiny. Also ways in which children are viewed and perceived have been shown in interactions surrounding illness. Children do not just make claims of feeling unwell but have to be able to convince adults of this. Christiansen (1998), for instance, argues that how children are seen largely determines how they are treated. That is, in her view, a child's competence and what it implies in dealing with illness is a matter of representation within the child's particular context. There is therefore some kind of distinguishing boundaries between adults and children, which in turn reflect in interactions, as Christiansen points out,

...may, in regard to children suggest that to establish the norm of the adult as an independent, responsible and competent person necessarily constitutes its opposite which at the same time is its complement through notions of vulnerability, dependency and incompetence in children. (1998:188)

Van Reeuwijk (2010) has exemplified this vulnerability in children dealing with their healthcare issues in a setting of HIV/AIDS prevalence. In her study of children of primary school age in northwest Tanzania, she takes the position that adults' view of children as vulnerable renders children's own understanding of their bodily experiences as irrelevant. Van Reeuwijk emphasises that vulnerability should be seen as situational and relational; that is, vulnerability is not fixed but changes with the ways in which society views and relates with children. In her view, if children's ideas about their bodies are taken into consideration and their voices are heard rather than muted, HIV/AIDS interventions would be more successful.

In relation to how context plays a role in how children's competence in their illness experiences is constituted, Mayall (1993) argues that children's activities are deeply shaped by adults' understanding of their status either as socialization projects or as participatory actors. Focusing on the division of labour in healthcare between children, parents and teachers at home and school in the UK, she observes that while the school considered the children as projects that needed to be executed in the best way possible, mothers conceptualized their children as people with a drive towards independence and with a contribution to make in the social world of the family (1993: 484). Although not specifically about ill children, this study draws attention to how differing outlooks of children in different contexts has implications for children's participation in and negotiations with their health experiences through interactions with adults.

Again, the ways in which children are viewed translates into how they are treated and responded to, which in turn generates some kind of tension between adults and children. There is thus a constant, ongoing negotiation between children and parents. Christiansen (1998) exemplifies this in a study of Danish children's experiences and interactions during everyday episodes of illness and minor accidents. Using, among other methods, participant observations, interviews, drawings and drama, the study shows that adults view children's illness complaints from an etic perspective. Even though children are exclusively privy to their own subjective bodily experiences, they are still not considered 'speakers of fact' of their own body and so not considered capable of translating a bodily experience into a disease state or condition (1998:194). In this way, children's competence is suspended. The adult then relies on what Christensen describes as 'objective evidence in the child's body' such as duration of symptoms, time and 'passive' waiting and temperature taking to validate, or not, the child's claim. Alternatively, her study shows through pharmaceutical use how children are able to negotiate their competence within the 'rigid' relationship regarding healthcare with adults. This is especially so for children with chronic ailments who have to use medicines constantly. However, in these children, their competence is not only seen as different to that of adults, but also to normal healthy children.

Using a conversation analysis of ordinary family talk during meal times, Jenkins (2015) also exemplifies the social study of childhood's notion that children exert agency and negotiate with adults in their ill health situations. In this study, while parents may rework a child's complaint of being unwell, children display their ability to deny or accept these reformulations. Thus Jenkins argues that children can and do object to parental descriptions and causal explanations of their complaint. Through the processes of talk in interaction, children display how their expression of pain is built, maintained or resisted by parents at home. The study illustrates how children are not passively subject to their parent's versions of their illness experience but rather actively negotiate the nature of their pain and physical experiences through mundane family interactions. Although conducted on a micro level, the study demonstrates how children are health actors from an early age and the ways in which their knowledge of their own bodily experiences are denied or shaped by more dominant adult understandings.

In negotiating illness experiences and performing healthcare, the role of mothers has been stressed (Prout 1986, 1988; Mayall, 1993, 1998). As Graham (1984) points out, healthcare is one of mothers' principal functions. Prout (1986), for instance, shows that teachers call into question the rearing practices of parents (mothers) when children present sickness complaints. The teachers in his study did this when children's claims of illness within the school setting were determined by their typification of the child-rearing practices of mothers. Thus teachers referred to children whose mothers they considered overindulgent as 'wet'. Such children's claims of illness were never taken seriously.

From mothers' own perspective, the activities surrounding the illness experiences of their children define their view of themselves as mothers (Prout, 1988). Prout identifies that mothers rely on instincts, their knowledge of their children, the health history of the children, noticeable symptoms, and a break in habits as ways of checking the genuineness of children's claims of feeling unwell. Although mothers seem to have a hold on making these decisions, the children point out that if they were determined and persistent with their claims they stood a good chance of getting their claims validated by their mothers. Prout broadly

represents mothers' decision-making about the illness claims of their children as emotional upset and training in stoicism. That is, either the child is going through an emotional disturbance such as moving house, or in the case of stoicism is too soft and less able to endure and so translates these feelings into illness claims. However, Prout cautions that it is not a straightforward decision-making process for mothers, but works as a system of possibilities that are highly reflexive (Prout, 1988: 774). What this lays bare is that the illness experience of children is an ongoing process embedded in interactions and interrelations with adults. The present study locates this process within a particular context (Ghana) and brings out how this negotiating process plays out within the existing relational boundaries.

Central to the studies discussed above is the use of qualitative, participatory research methods such as drawing, essay writing, participant observation, and children as co-researchers and interviews. These follow the emphasis on the use of interactionist approach in doing research with children as it allows children a voice in the research process, and facilitates small-scale research of children's illness experiences. Although some African perspectives have been represented, including Uganda (Akello, 2010; Wasike, 2007), Tanzania and Zimbabwe (van Reeuwijk, 2001; Bernays et al. 2015), Kenya (Geissler et al. 2000; Geissler et al. 2001; Onyango-Ouma et al. 2004) and Benin (van Reeuwijk, 2001), the majority of studies have focused on Western societies. Moreover, for the studies within the African context, the emphasis has mostly been on specific biomedical disease categories such as malaria, diarrhoea, fever, typhoid and HIV/AIDS. This study departs from existing categories to look at children's illness complaints that have not yet been medically labelled. This is to enable a deeper look into how children make sense of illness even when there is no name for it and to see if these bodily feelings are framed biomedically, and if so in what ways. Further, within these studies set in Africa, the relational and interactional aspects of child-adult relationships surrounding children's illness experiences have not been aptly delved into, leaving room for this to be looked at.

Again, it is apparent from the discussion of the literature that there is hardly any work within the Ghanaian context that privileges the voices of children in making

sense of and dealing with illness. Health research over the years has focused on adult perspectives (see van de Geerst and Krause, 2014). Health research that has included children in this context has focused largely on the mortality rates of under-fives (see Boadi and Kuitunen, 2005; National Development Planning Commission and UNDP Ghana, 2010; Tagoe-Darko and Gyasi, 2013; Owusu and Appiah, 2013), mothers' perspectives, health-seeking behaviour for young children (Ross et al. 1993; Hill et al. 2003; Boadi and Kuiten, 2005; Adjei et al. 2009), and common tropical diseases among children (Binka et al. 1996; Biritwum et al. 2000; Mockenhaupt et al., 2004; Ahorlu et al., 2006; Adjei et al., 2009). Thus research on children's illness situations in Ghana has relied on adult interpretations and interventions. In instances where studies have directly involved children's voices, the focus has mainly been on child labour, child poverty, and the United Nations conventions on the right of the child (Twum-Danso, 2009; Twum-Danso, 2010; Tetteh, 2012; Adu-Gyamfi, 2014).

However, as indicated earlier, Ghana presents a context where socio-cultural values surrounding children largely see them as powerless and adhering to strict hierarchical relations. These values translate into policies that concern children. Specific to this study is the health institution, which is largely dominated by adults, and where children above the age of five are treated as passive recipients of care. Yet the country is not untouched by social change, causing changes in lifestyles and the kind of values that are prioritized (Oppong 2006; Therborn, 2006). This may have implications for child-adult relations and the extent to which children are capable of exerting influence in their illness experiences.

In view of this, this present study is set within a context where there is paucity of documentation on children's illness experiences from their own perspective. It also focuses on undiagnosed complaints of feeling unwell by children. In focusing on these complaints, it allows the consideration of a kind of triple hurdle, that is, the complaints are weak, there is no diagnostic criteria yet or even words to describe these feelings, and there is no adequate structural policy that deals with the health needs of children above the age of five. The contribution that this study makes is to highlight how children's competence is constituted in a setting where their influence on their lives is perceived to be minimal or even

non-existent and so proves useful in contributing to the body of work within the child agency tradition in a setting other than a Western society where research has advanced in this regard.

2.3 Theoretical framework

With a focus on understanding Ghanaian children's illness experience in their everyday interactions with adults, my study relies on a number of theoretical concepts. These include child agency (Prout, 1988; James and Prout, 1997; Alderson, 1995; James, Jenks and Prout 1998; Prout, 2001; Prout, 2005), generation (Manheim, 1952; Alanen 2001; Alanen and Mayall 2001; Mayall, 1998, 2015), health-seeking behavioural models in a context of a pluralistic health care system (Kleinman, 1980; Good, 1994; Asenso-Okyere and Dzarto, 1997; Asenso-Okyere, Anum, Osei-Akoto and Adukonu, 1998; Tipping and Segall, 1995) and medicalization theory (Szasz, 2007; Conrad, 2007; Parens 2011). These theoretical concepts have been used to delineate the study, highlight aspects of the work and help to explain emerging issues in the data analysis around agency, relationships in interaction and illness behaviour. They are discussed in turn below.

2.3.1 Child Agency

Earlier studies within the social sciences about childhood and children relied on socialization theories in sociology and development theories in psychology (see Parsons and Bales, 1955; Clausen, 1968; Denzin, 1979). However, these are criticized for presenting children as passive, for defining children not as what they are but what they will become, and excessively focusing on the individual (James and Prout, 1997; Prout, 2005). Development theories in psychology are also noted as assuming universality in childhood and fixed criteria for transitioning from childhood to adulthood (James and Prout, 1997). These theorizations often result in researchers relying on the judgments and interpretations of adults to understand the lived experiences of children (Prout, 1988; James et al., 1998; Prout, 2001). Alanen (1988) laments the absence of the study of children in sociology and points out that even when present, children are treated within a limited context and considered marginal for sociological

theory and research. Qvortrup (1993) reiterates this observation by noting that children have not so much been ignored as they have been marginalized in the social sciences and this is due to their subordinate characterization in societies and theoretical conceptualizations of childhood and socialization which view children as forward-looking (quoted in Corsaro, 1997:7).

In response to the state of childhood studies in sociology, the concept of children's agency emerged, where children are seen as social actors whose relationships are worthy of study in their own right (James and Prout, 1997). Much of the impetus for viewing children as social actors stems from interpretative sociology which stresses the creative production of social life rather than the determination of social life by social structures (James and Prout, 1997).

The key features of this framework, as noted by James and Prout (1997), are as follows. Firstly, childhood is socially constructed, and is constituted in discourse and so distinct from biological immaturity. Thus, childhood becomes an analytical social category rather than an age category. Secondly, childhood is neither a natural nor universal feature of human groups but instead a specific structural and cultural component of many societies. James and Prout also observe that there are many varieties of childhood rather than a single and universal category. Further, they point out that children should be seen not merely as passive objects of social structure and processes but rather as active in the construction and determination of their own social lives and the lives of those around them. Finally, in studying the life of children, ethnography is advocated as a particularly useful methodology as it allows children a more direct voice and greater participation in the production of sociological data than survey and experimental methods do (Christensen and James, 2000).

Viewing children as social actors, active in the construction and determination of the social lives of those around them and the societies in which they live, leads to more complex explorations of the ways in which children exercise agency (Holland, Renold, Ross and Hillman, 2008; James and James, 2004). It also takes into consideration and recognizes a range of cultural and social norms that regulate, to no small degree, children's ability to make choices in several

contexts, from the family to the broader community, which consistently construct children as relatively passive and powerless (Brady, Lowe and Lauritzen, 2015). Thus, the social and cultural contexts in which children live should be considered primary influences when making sense of the social world of children (Holland et al., 2008). In sum, the strength of this guiding frame lies mainly in its ability to allow a certain kind of specificity to understand the mundane experiences of children.

However, the framework stresses agency, and seems to isolate children as operating in a vacuum. It does not appear to specifically relate them to the existing social institutions and to account for children as both constrained by the social structure and as agents acting in and upon this structure (James and James, 2004). It thus hinges on the problems of the structure-agency dichotomy in sociology (Giddens, 1979; Prout, 2005). A more nuanced approach is necessary. For instance, Giddens' theory of structuration argues that sociologists must grasp both agency and structure and that these are two sides of the same coin (Giddens, 1979). Giddens further posits that social life is beyond random individual acts. These acts are guided by pre-existing social structures and norms which are constantly reproduced and modified by human action (Giddens, 1984).

In addition, the emphasis on a locally constructed childhood, which is often the basis and dominant preference of many childhood scholars, tends to ignore some aspects of social change in society. For instance, Lieten (2008) observes that locally constructed childhood tends to ignore the various economic, cultural and social attributes of a modernizing, globalizing world. He points out that even communities that hitherto maintained or upheld their sociocultural values are confronted by outside influences. Further, Lieten argues that what becomes important is a focus on social relationships rather than different childhoods, as the idea of different childhoods may only be because of a globally lopsided economic system (Lieten, 2008).

Moreover, the concept of children's agency prescribes research methods that directly involve children. These methods are used in empirical studies with

children mainly in Western societies (Prout, 1986; James and Prout, 1997; James et al., 1998; Mayall, 2015). In adopting a similar framework to study non-Western societies like Ghana, caution must be exercised. For instance, in her study of the views of Ghanaian children on the UN Convention on the Rights of the Child, Twum-Danso (2009) realized that adults found it problematic that children were the only participants in the study. This approach made parents and guardians reluctant to allow their children to participate in the research, or they were continually interfering in the process.

Further, childhood can be looked at as an embodiment of social processes and conditions including but not limited to gender, class, power relations between children and adults, and age (Lareau, 2002). The focus of this work is to consider the extent to which these factors may determine children's active participation in their illness experiences in Ghanaian society. This framework does not precisely capture this aspect and so becomes deficient on its own in this regard.

2.3.2 Generation

Given the limitations of the concept of agency on its own, a more clear-cut approach should be used to explore the structural conditions that shape childhood as a generational space since this will ensure that one does not lose sight of the differential impacts that societal forces such as the state, urbanization and social class have on childhood (James and James, 2004; James, 2007). This position becomes useful in viewing Ghanaian children—whose agency is mostly assumed to be inhibited by culture and socialization processes—within the society and so presenting a different kind of childhood (Twum-Danso, 2009; Adu-Gyamfi, 2014). The nature of childhood may have more to do with the underlying structural conditions that prevail, and so different versions of childhood will then exist given one's position within the Ghanaian social structure, not necessarily determined by culture. Lieten (2008), for instance, argues that childhood may be more class-specific than culture-specific. There is thus a need to explore the potential of children under different social circumstances in Ghanaian society, and how relations play out within these circumstances, to make sense of their mundane illness experiences.

In this regard, the concept of generation becomes useful as a guiding frame and for complementing children's agency. Alanen (2001) proposes generation in understanding children's relations with adults within society. This concept draws on Mannheim's seminal work which considers generation as consisting of people who are exposed to broadly the same set of historical, cultural or political events and movements (Mannheim, 1952). Alanen and Mayall (2001) outline the tenets of the concept. Firstly, individual children and adults interrelate across age divisions, power inequalities and household norms and needs. Secondly, relationships are constituted between social groups; that is, the social group of children and the social group of adults interact across generations with different interests and needs all shaped by social norms and policies. Thirdly, adults belong to a different generation to children: they carry with them knowledge, assumptions and experience acquired over their lifetime, and are influenced by the social forces in place in their lifetime.

In furthering this, Mayall (2015) points out that from a sociological point of view, individuals or groups are better understood by identifying and analysing the relationships between and among them. Children are often set apart as belonging to a separate generation from adults but at the same time must work towards establishing their identities and social lives through intergenerational relationships (Mayall, 2015). Generation then becomes key to understanding childhood as a social phenomenon and the experiences of children in living childhood (James and Prout, 1997; Mayall, 1998). In conceiving childhood within the concept of generation, children can be viewed as a minority group in society in relation to parents and social structures (Mayall, 2015). For instance, it has been documented that children's access to healthcare and education are largely tied to their parent's socio-economic position which in turn is dictated by the operations of social policies and their agents (Kapinga, 2014; Case, Fertig and Parson, 2005).

Exploring generation, within which childhood is continuously produced and lived, still maintains the underlying understanding that children are agents (Alanen, 2001). However, children are considered not merely actors and persons who have perspectives on their lives but are also understood as agents whose (lack

of) powers to influence and engage with structures are to be studied (Alanen and Mayall, 2001). Generation has further been noted as a powerful analytical tool for studying society because it implies relations in time with connections, contrasts and often conflicts (Whyte, Alber and van der Geest, 2008). In addition, members of a generation do not submit to the cultural and societal position they find themselves in but instead use that position to pursue their interest and to influence their lived circumstances (Whyte et al., 2008). Thus it enables an understanding of the point of convergence as well as the contradictions that exist in child-adult relations and how these play out within a particular context.

In using generation, children are not considered to be operating in a vacuum. Instead, they are seen as showcasing their position in a relational parameter in dealing with adults within a broader societal structure (Mayall, 2015). That is, the concept allows an understanding of how children's lives are structured within the relationships that they have with adults and also adults' knowledge of what children are and how their childhoods should be lived. Contextualizing children's perspectives within generational relationships helps to succinctly consider both the micro and macro establishments within a society that influence children's lives. A generational relationship then becomes key in examining the nature of the layers of social relations that exist in a society, and how linked these layers are to each other in enhancing or curtailing children's agency (Mayall, 2015).

By placing this present study within this frame, it provides an opportunity to view Ghanaian children as living their everyday lives within a structure that regulates the nature of interactions, the relations that exist and the related opportunities. It also allows an exploration of the socioeconomic conditions that prevail in the society at a particular time, to understand the interplay between these and the kind of childhood experiences they permit. Further, it proves crucial in aiding an understanding that the practices and meanings children attach to their experiences are not created in isolation. Instead, these are made possible through relationships with adults, who constitute and coordinate these practices. Within this context, too, the framework permits the inclusion of adults in the data collection process to avoid them feeling they have been stripped of their power, which may affect the process.

2.3.3 Health-seeking behavioural models in a context of pluralistic health care

This study also considers how children's illness experiences play out within relations between children and adults. In studying the illness experiences of children within the ongoing relations with adults, I rely on health-seeking behaviour as a framework to situate this aspect of the research. Kleinman (1980) asserts that every society has three, often overlapping, sectors of healthcare: the popular sector, the professional sector, and the folk sector. The popular sector includes all therapeutic actions that people utilize without relying on any healers either in the professional or folk sector. The main arena where this takes place is the home where illnesses are first defined and healthcare initiated. What is common within this sector is self-medication, self-treatment, and advice given by friends, relatives and workmates (Kleinman, 1980). The professional sector is made up of organized, regulated professionals. Kleinman indicates that in many countries, biomedicine has become synonymous with the professional sector, while the folk sector is operated by either secular or sacred healers with little or no formal training compared with those in the professional sector. Healers in this sector occupy an intermediate place between the popular and the professional sectors. Most of them also share the cultural values of the communities in which they live and operate. Examples of this sector include herbalism, shamanism and ritual curing (Kleinman, 1980).

This typology serves as a starting point to think about health seeking. It is, however, also relevant to gain an insight into the dynamics at play in the healing practices of lay people. Kleinman (1980) and Good (1994) have argued that dealing with illness is influenced by, among other things, age, gender, and differences in social positions within the household. Illness behaviour is described as a logical sequence of steps that are followed to seek a cure. Other models focus on a set of variables which explain health-seeking behaviour and the choice of different forms of healthcare (Fiereman and Jansen, 1992; Mechanic, 1992; Asenso-Okyere and Dzator, 1997; Asenso-Okyere et al., 1998; Tipping and Segall, 1995). These variables include recognition of and significance attached to the symptoms, perceived seriousness of the illness, the persistence of the illness, the perceived cause, knowledge of illness remedies and faith in

the efficacy of the medicine available. Economic factors such as the price of medicine, distance from the healthcare services, time-related costs and gaps in communication with healthcare personnel have also been identified (Mechanic, 1992; Asenso-Otchere et al., 1998; Tipping and Segall, 1995). It is noted that these choices are an outcome of a hierarchical sequence of transactions by the actors seeking health care.

Tipping and Segall (1995) provide seven useful and more nuanced determinants of health-seeking behaviour which consider socio-economic variables such as level of education, marital status, maternal occupation, economic status; age and sex; the social status of women; healthcare costs; the type and severity of illness; the patient and doctor relationship; the perceived quality of service provision; and the distance and physical access. In all these models, however, there is the underlying assumption that social actors are rational in their choices and follow a sequence of choices to arrive at the most appropriate option. In real lived experiences, this has proven to be more complicated (Asenso-Otchere and Dzator, 1997).

Further, Tipping and Segall (1995) conclude that health-seeking behaviour relates to the adequacy of household resources, but evidence shows that such a conclusion is an oversimplification since many variables come into play when dealing with illness (Asenso-Otchere et al., 1998; Senah, 1997). Also, the variables that have been outlined do not explicitly take into consideration the particular context. How these variables play out may be different based on the kind of policies that exist concerning healthcare. For instance, in a context like Ghana where commodification of healthcare has inadvertently fetishized pharmaceuticals as a critical component of healthcare delivery, health-seeking may play out differently from a context in which pharmaceuticals are regulated (Senah, 2001). Importantly, the healthcare utilization models that have been developed are adult-centred and do not consider the place or role of children (Akello, 2010). Studies, however, point to children as active seekers of health care and cure (Geissler et al., 2001; Wasike, 2007; Akello, 2007; Akello, 2010). Further, in Ghana, literature on the health-seeking behaviour that explicitly relies on the perspective of children is almost non-existent (see Hampshire et al., 2011).

Available studies target adults such as mothers as caregivers. The usefulness of this study lies in its contribution to an understanding of health-seeking behaviour that relies on the perspective of children and their lived experience of illness.

2.3.4 Medicalization

Medicalization describes the social process by which personal troubles and needs are translated into medical terms and treated by medical experts (Emerson and Messinger, 1977; Conrad and Schneider, 1980). The focus on everyday interactions and illness complaints in this study allows an interrogation of the extent to which mundane experiences are medicalized in a context where medicalization is less pronounced; that is, whether medicalization exists in Ghanaian society, and how within relations and interactions between children and adults it is utilized or not.

So far, the dominant thesis on medicalization has been top-down in approach: the focus has been on 'powerful adults': medical professionals, policy-makers, and pharmaceutical companies (Szasz, 2007; Conrad, 2007). Studies that have employed a bottom-up approach have centred on activists influencing medical practices, knowledge of diseases passed on through social networks and patients influencing how doctors should interpret their symptoms (Brown et al. 2004; Edwards, Howlett, Ackrich and Rabeharisoa, 2014; Liu, King and Bearman, 2010). Also, Parens (2011) has observed that when sociologists use the term medicalization, they traditionally assume that the process it names is a bad one. He further argues that medicalization is not necessarily a bad thing in so far as some forms of it can maintain or facilitate human relationships and experiences.

This study emphasizes everyday social relations and interactions between children and adults concerning illness. In the medicalization literature, children's pragmatic attempts at dealing with illness, and their perspectives, are underrepresented if not non-existent. This present study therefore offers a useful contribution as it opens up discussions on ways in which diagnostic labels are used by children to handle their subjective bodily sensations. This in turn enables a bottom-up analysis of the conceptualization of illness that is not largely documented within the medicalization literature from the perspective of less

powerful social agents, namely children. As the study focuses on undiagnosed complaints it shifts the focus from the dominant approach of the medicalization proponents—on patients who have already been exposed to health personnel, diagnostic labels and treatment—to how and where medicalization may function as a tool for children to make sense of the disruptions that occur in their everyday routines.

2.4 Conclusion

This chapter has outlined the relevant literature surrounding children's perspectives in dealing with not feeling well. Ethnographic studies have been undertaken in line with the 'competence paradigm' to bring out children's own perspective in this regard. Research has focused on both Western and non-Western contexts, where policy and social cultural values around children differ. Gaps have been identified such as the paucity of children's own perspective in their illness experiences in Ghana, and the lack of emphasis on the role of social class in child-adult interactions in relation to illness in contexts similar to Ghana which this study addresses.

To concisely situate and organise the study, four theoretical concepts have been relied upon: child agency, generation, health-seeking behaviour and medicalization. These help to address the aspects of the study including children's competence, child-adult relations and illness experiences. The next chapter discusses the physical and social environments as well as the social actors that have been considered in the study.

3

The social and physical space in which the study is situated

3.1 Introduction

It is necessary to describe the location and composition of the area in which the two schools relied on for data are located as well as the schools themselves. In this way it will enable an acquaintance not only with the physical environment but also the social actors that make up that space. I give a brief description of Sagnarigu where the schools are located and then delve into the physical and social environments of the schools. However, it must be pointed out that pseudonyms have been used for the names of the schools and some defining characteristics have been changed to ensure the anonymity and confidentiality of the participants. A detailed discussion on this as well as the criteria for selecting these schools is provided in chapter 4.

3.2 The Sagnarigu Municipal Assembly

The Sagnarigu district was created in 2012 out of the Tamale Metropolis which is the capital of the Northern Region, one of the ten administrative regions of Ghana. The district was elevated to the status of a Municipal Assembly in 2017. It shares boundaries with Savelugu Nanton Municipality to the north, Tamale Metropolis to the south and east, Tolon District to the west and Kumbungu District to the north-west (Government of Ghana, 2016). The municipality, just like many other municipalities and districts in the region, has a single rainy season spanning May to October with a peak between July and August. There is also the dry season characterized by dry Harmattan winds which mean two extreme weather conditions: extreme dry cold weather at dawn and in the mornings, and very warm temperatures in the afternoons (Ghana Statistical Service [GSS], 2014).

According to the report of the Ghana Population and Housing Census of 2010, the population of the area is 148,009, which represents six per cent of the region's total population (GSS, 2014). The same report indicates that the population of the district is largely youthful with ages 0-14 constituting 37.5 per cent of the population. It is ethnically diverse in composition. Dagomba is the main ethnic group with others such as the Gonja, Mamprusi, Dagaaba and Akan.

The social and physical space in which the study is situated

The major religion is Islam (83.5 per cent), while others subscribe to Christianity or traditional religious beliefs (GSS, 2014).

The municipality is made up of 23,447 households with an average household size of 6.3 persons. The extended household composition of a head, spouse(s), children and the head's relatives is the dominant structure (GSS, 2014). In addition, children constitute the largest proportion (43.3 per cent) of the household composition. Overall, 69 per cent of dwelling units are compound houses, in which more than one household shares a house and the facilities available in the house. The rest include separate houses (13.0 per cent) and semi-detached houses (5.0 per cent).

More than half of the population (59.1 per cent) are literate in both the English language and a Ghanaian language (GSS, 2014). In the case of children, 53.6 per cent are literate in the English language. This is not surprising as most of the children encountered in the study speak and write English. The main economic activities and occupations of people in this area include service and sales workers, crafts and related trades, clerical support workers, skilled agricultural and fishery works, managers, professionals and technicians (GSS, 2014).

In terms of health, fifteen functional health facilities have been noted in the municipality: two private hospitals, one private specialist facility, one private clinic, three government-owned clinics, three Community Based Health Planning and Services (CHPS) compounds, three private maternity homes, one nutrition centre, and a Planned Parenthood Association centre (Government of Ghana, 2016). This goes to illustrate the public-private partnership in service delivery in Ghana (Aryee and Crook, 2003). In addition, there are about 299 educational facilities in the municipality that are managed by the Municipal Education Directorate. Of this number, 122 are primary schools (Government of Ghana, 2016). Two of these primary schools, namely Baobab Primary School (BPS) and Shea Nut Primary School (SNPS), were the focus of this study.

3.3 Baobab Primary School (BPS)

According to the authorities of BPS, the school was established in the latter part of the 1980s by expatriates who were working in Tamale and needed a place to keep their children engaged during the day. Other expatriates who were largely working in the construction industry also started using this daytime arrangement. Over time, their Ghanaian engineering partners expressed interest and their children were accepted to be part of the new establishment.

At first, the school had less than thirty pupils, and since it was an informal arrangement the children did not have to wear a uniform to school as is typical of Ghanaian schools. But then it became a well-known private school in the northern region of Ghana with a high population of expatriate children and a few Ghanaians. According to the school authorities, a few years after its establishment, the school ran into financial difficulties because most of the expatriates had left the country after their job contracts were ended, or they transferred their children to schools in Europe. The school then sought assistance from the government and became a government-assisted school. That is, the government supplied and paid for most of the teachers. However, up until the present day, the school continues to charge levies to parents to pay the salaries of support staff such as cleaners and to cater for the welfare of teachers.

The school is located within the Sagnarigu Municipality in the northern region of Ghana. It is cited close to residential homes and shares boundaries with other private schools in the area. It is accessible from the Tamale-Bolgatanga highway and the Gurugu-Jisonayilli link road. The school has a population of about six hundred children. This number comprises the crèche, nursery, kindergarten, primary school and junior high school. There are about 35 teachers and some support staff including the school secretary, accountant, security man and cleaners.

Although the authorities of BPS do not refer to the school as a private school anymore, it maintains some features of a private school in Ghana. One easily

identifiable trait is that parents are charged school levies agreed on by the Parent Teacher Association (PTA). This levy is higher than what many government schools permit because basic education in Ghana is considered free, compulsory and accessible to all (Article 38 of the 1992 Constitution of Ghana). In addition, the PTA in BPS is very powerful and decisions from this association have a greater sway on the school than government directives. The PTA carries out its work through subcommittees: Education, Infrastructure, Procurement and Finance. There is however no health committee and when I inquired, I was only told there is not one and that the existing committees reflect the priority areas for the school.

Further, admission into BPS can be a very tedious endeavour, since the school intentionally limits the number of children in order to make teaching and learning effective. Admissions are the sole prerogative of the school board under the PTA. This is not so in state schools as admissions are often the preserve of the school's head teacher. According to the school authorities, before a child is admitted into BPS, exams are conducted. When the child passes the exam he or she still has to undergo an interview session with his or her parents before an admission decision is made.

Although the government supplies the school with teachers, the school employs and pays some teachers in subject areas that are not covered, or is felt they do not have enough of. These subjects include science, mathematics, French and Dagbani, which is the local Ghanaian language widely spoken in Tamale. Teachers are also employed in subject areas that are not on the curriculum for primary schools in Ghana such as music and dance. The school authorities point out that when employing these teachers, although this is not regularly done anymore, they are interviewed by a subcommittee of the PTA, namely the Education Committee. When employed, a teacher is given a three-month probation period with an extension subject to their performance including an appraisal by the children. Thus, the PTA relies to some extent on the opinion of the children to decide on the fate of some teachers. All the teachers are subject teachers, and teach specific subjects only. However a teacher is assigned to each class as a class teacher with the duty of marking the class register every

morning and compiling the continuous assessment and report cards at the end of the term for each child.

Besides teachers, the school also employs cleaners and a security man (watchman). Cleaners take charge of the day-to-day cleaning of the school compound and the classrooms of the crèche, nursery, kindergarten and classes one, two and three. From class four to junior high school three, the children clean the classrooms themselves, at the end of the day before they go home. The security man sits at the entrance of the school all day and also watches over the school premises after the school day is over. He is usually the first point of call for any visitor.

3.3.1 The physical environment of the school

The school is surrounded by a wall with a gate at the entrance. The security man is stationed at the entrance most of the day. The school compound houses the crèche, nursery, kindergarten, primary school and junior high school departments. There is also a staff common room, computer laboratory, library, accounts office and head teacher's office. Also within the compound is a shed-like structure popularly referred to as the 'summer hut'. Some teachers sit under this shed to prepare their lessons and correct assignments, and some children wait here to be picked up by their parents while others have their lunch there. Teachers who own motorcycles and children who use bicycles to commute to school park them at the end of the shed.

Within the buildings are a bathroom and water closet type toilet facility. There is one bathroom and three toilet cubicles in each block: one for girls, one for boys and a third one marked for teachers. That is, children and teachers do not share facilities. There is a sink-like space that is tiled with five taps connected to an underground water reservoir and water tank. The children usually wash their hands here and also drink the water from the tap.

A cluster of neem trees stands close to the school entrance. The school playground shares this scanty shade with the food market. In the playground there are swings, slides, a merry-go-round and climbing frames where most of

the children in kindergarten and lower primary play during break time. The food market is made up of a group of women who sell food placed in either pans or coolers. The food sold here includes wheat porridge with slices of bread, rice and beans with stew popularly called 'waakye', corn dumpling with fresh ground pepper, fish called 'kenkey', fried yam with pepper, and fried fish. Another woman sells pastries such as meat pies, sausage rolls and doughnuts. A female teacher has a table at this spot where different types of sweets, fruit drinks, sodas and biscuits are displayed for sale to the children. At the close of day, some other sellers come to sit at the entrance of the school and sell ice cream and other sweets. Parents usually buy these for the children on their way out of the school compound when they pick them up.

Further, in the vicinity is a small space that has been cemented and used for the 1.00 pm Muslim prayers by the teachers. This is usually a couple of minutes after the second break. I have however observed on a number of occasions when some of the boys joined teachers for these prayers. I have not seen any girls join for prayers. Some of the children pointed out to me that they are not properly dressed to join in the prayers if they wanted to. This is because they do not wear veils or the hijab to school.

Close to the food market is one classroom block that is yet to be completed. This building has a large hall which is used for music and dance lessons. To the extreme north of the school is a bare field that is often used by the boys for playing football during physical education (PE) lessons and during break times. In the rainy season some parts of it are bushy but in the dry season it is bare and sandy. There are a number of trees consciously planted all over the school compound, such as shea, mango, neem and lemon trees. Some of the children group under the trees during break to converse, have their meals or wait to be picked up by their parents at the end of the day.

3.3.2 The head teacher's office

Across from the block housing the staff common room is the head teacher's office. In this office there is a large table with files arranged on it. There is a swivel chair on which the head teacher sits and two other chairs facing him for visitors to his office. There are several shelves with books and files, and a clock on the wall. On one of the shelves, trophies and plaques won by the school are displayed. On one of the plaques is the inscription 'Best Performance in BECE in the Northern Region'. The BECE is an assessment examination organized by the West African Examination Council to mark the completion of junior high school and the qualification to get into senior high school in West Africa.

On the right side of the wall closest to the entrance of the head teacher's office is affixed a wooden first aid box and on top of it is a plastic box with a lid that contains packs of gauze, cotton wool and plasters. Inside the first aid box are two medium-sized plastic containers with paracetamol and two containers of 'aludrox' (Aluminum Magnesium Trisilicate). There are also bottles of Gentian Violet, Methylated Spirit and Povidone Iodine. Wraps of cotton wool and gauze have also been packed inside the box. Besides these, there is another plastic box with a lid on the table of the teacher in charge of medicines a few metres from the head teacher's office. Inside this box are smaller packs of cotton wool, gauze and smaller bottles of Gentian Violet, Methylated Spirit, Povidone Iodine and a pair of scissors.

The school secretary is often seen walking in and out of the head teacher's office. Teachers also go in from time to time to have discussions with the head teacher. Parents also come to see the head teacher in this office. It was observed that usually when a child goes to the head teacher's office he or she waits outside until the head teacher invites the child in. This is a rare occurrence. Aside from the head teacher's office and the staff common room, there is an office for an accountant. This is where all school fees and levies, as well as welfare allowances, extra tuition allowances and salaries of teachers who are employed directly by the school are paid. This office is often shared by the school accountant and the school secretary. Close to the head teacher's office

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is the school notice board where the schedule for the term, activities for the term and duty roster for teachers are posted.

3.3.3 The classrooms

In the classrooms, with numbers of pupils ranging from 40 to 42, each child has a metal table and chair. In each class there is a white board with non-permanent markers for writing on them. In addition, each classroom has lights and a ceiling fan. In hot weather, the fans are turned on to cool down the room. The classes also have windows made of louvre blades and a window net covering. All lessons are held in the classrooms except music and dance and physical education (PE). There is no teacher for the PE lessons, so what usually happens is the boys go out to play football on the school field, unsupervised, while the girls remain in the classroom to chat in groups. Sometimes, teachers use this lesson slot as additional time to teach their lessons, to 'occupy' the children or keep them engaged.

There is also a computer laboratory on the school premises. Inside the lab are desktop computers where the children go for information, communication and technology (ICT) lessons. The children also have periods for library time. However, the few books that are available in the school library are very old, worn out and torn. This room is often used as some kind of infirmary when children complain about feeling unwell. A mat is spread across the floor and children lie on it. From time to time some teachers who are tired also go in there to relax.

3.3.4 The Staff Common Room

The staff common room is one of the most popular spaces for both teachers and children at BPS. It shares the same block with the class one to class three classrooms. It is furnished with sofas, bookshelves, a long work table, chairs, a refrigerator and a TV. The master timetable for class schedules for the whole school is posted on the wall of the staff common room. Every day, the teachers and support staff are provided with some form of snack—tea, coffee and biscuits—in the staff common room. This is where teachers relax and watch television. They also correct assignments and homework as well as prepare lesson notes here. Staff meetings at the beginning and end of the school term

are held in this room. A child who is considered to have gone against school rules is questioned in the staff common room. Teachers also send for children who have excelled in their subject areas to show them off to their fellow teachers:

There were about six teachers in the staff common room, each absorbed in whatever he or she was doing: correcting assignments, scrolling on their mobile phones or eating. Just then one of the science teachers walks in with a boy in class three, with his arms around the boy's shoulders. He heartily says 'herrrh... here is our next Einstein eh. He will definitely be in the National Science and Maths Quiz'. He then takes his arms from around the boy's shoulders and playfully nudges him, and the boy runs off to class. One of the teachers whose attention he has drawn remarks that the mathematics teacher said the same about the boy. (Field notes 20th October 2016).

Children are discussed by teachers in this space. Remarks are made about those who are working hard as well as complaints about those they think are lazy and 'difficult' to deal with. It is also a place where teachers lament about their conditions of service and make comparisons with other private schools they have heard about. Ongoing political discussions in the country are debated by the teachers every day. The TV in the room is often tuned to political discussions and the teachers carry on the debate long after the shows are over. Marketing and insurance companies usually meet the teachers in this room to market their products.

The staff common room is also a space where children come to fetch teachers for lessons and bring back books for marking. In addition, children come to make complaints to teachers here. It is very common to find children walk in and complain about a classmate bothering them or about not feeling well. However, when it comes to feeling unwell, some of the children state that they prefer to report to the teacher when he or she is alone:

If you go and tell them in the staff common room especially Teacher C...he likes that. He will say that I am lying but it is true. So I'll look for Teacher S and

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tell him. He most at times [often] sits by our class. (FGD with class 5 girls, 7th November 2017).

I have observed a situation where a boy walked into the staff room and complained about being kicked by another boy. Before the teacher whom the boy reported to could respond, another teacher waved him off, saying that he is a 'trouble causer' and that he might have started the attack in the first place. There was nothing more to be said and so the boy walked out deflated. Thus, although it is a space for making complaints, not all the children find it a safe space because of the opinions and presence of some teachers.

Further, the younger children often run into the staff common room when they are pursued or being threatened to be beaten by their classmates. They run into the room and when they are sure the person pursuing them has retreated, they run out. All of this is done oblivious to the presence of the teachers in the room. There are times when the room is empty, children walk in and sneak their exercise books into the pile of books for their class without the teachers finding out:

Two girls walk into the staff common room. One of them rushes to the table while the other stands by the door and intermittently looks outside. The girl at the table scans the different piles of books quickly. As she turns to another pile our eyes meet and she hesitates a bit. She did not realize I was seated in the room. I smile and she smiles back. She goes back to scanning the piles of book. She moves closer when she finds the pile she is looking for. She lifts the books from the middle and inserts her book. She then walks out to meet the other girl and they walk away. (Field notes, 8th November 2016).

The staff common room, although designated for teachers, is not only used by them. It is observed that teachers and children consider it both as a safe and unsafe space for interacting. On the part of children, this is so because they can come in here to complain to teachers and at the same time they are careful of certain teachers who they consider a nuisance in their bid to make complaints. For the teachers, it is a relaxing environment but at the same time a place to be

wary of the things that are uttered especially those related to the administration of the school and certain parents. The description of this space lends weight to the nature of relations between teachers and children of this school as will be illustrated in chapter six.

3.3.5 A typical school day at BPS

School activities largely revolve around and within the physical structures described above. School usually starts between 7.45 am and 8 am. From 7.15 am onwards most of the children begin arriving. By 7.45 am they gather for the morning assembly. The children form lines according to their classes. Two lines are formed by each class with the girls in front and the boys behind them. At the assembly, the Lord's Prayer (Our Father) is said. They also recite the national pledge with their right hand placed on their chest. After this they sing the national anthem, standing to attention with their hands at their side. Any child or teacher who arrives while the anthem is being sung stays wherever they, standing to attention, until the singing is over. After this, any announcements for the day are delivered and the children sing a marching song after a child is selected to give the tune and they march to class. The assembly is conducted by one of the children in junior high school, a prefect and supervised by a teacher on duty. Other teachers stand around to assist.

Often, some children arrive while the morning assembly is being conducted. They usually hurry to join their classmates in the assembly. Lessons begin at 8.00 am, and the first break of the day is from 10.15 am until 10.30 am. They continue lessons until 12.15 pm when they take a second break and return to class by 12.30 pm. Lessons continue from 12.30 pm until 1.45 pm when the official school timetable is finished. According to the timetable, three subjects are covered before the first break, another three before the second break and then two subjects before the third break. Each lesson takes 45 minutes. Thus, in a day they cover between four and five subjects as some subject blocks are held for ninety minutes. A bell is rung to signal the time to change lessons and to take a break. A boy in either class six or junior high school one is assigned the task of keeping the time.

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At 1.45 pm the children and teachers take a 15-minute break and return to class by 2.00 pm to have extra tuition for another one hour and forty-five minutes. Parents are made to pay an extra levy decided by the PTA for this tuition. It is compulsory for all children in class four up to junior high school. While these lessons go on, younger siblings who do not take part in extra tuition play or loiter around the school compound until their older siblings finish, and then they go home together. When the bell goes for the end of the day, the children in class four up to junior high school sweep their classrooms before leaving.

The children also celebrate the last day of the term, which is referred to as 'Our Day'. Previously, they were allowed to come to school in clothes other than their school uniform on that day, but nowadays they wear white shirts with their uniform or put on shirts designed by the school for them. They arrive in school with all sorts of refreshments and entertainment is provided by the school for them to celebrate. The school day is usually shorter on this day.

3.4 Shea Nut Primary School (SNPS)

According to the SNPS authorities, the school started operating in the early 1980s. It was established by the Catholic Church in the Archdiocese of Tamale. Besides the Sagnarigu Municipal Education Directorate, the school is managed by the Catholic Education Unit, since it was established by the church. The school is solely a primary school and supplies another Catholic junior high school close by with pupils. The two schools share the same compound but have different head teachers.

According to the school records, it has a total population of 683 children: 321 boys and 362 girls. These children are divided into 12 classrooms, from class one to class six. Each class is made up of two rooms, A and B, because of the numbers. The number of children in each class ranges from 60 to 65. There are 12 class teachers, two French teachers and one head teacher managing the day-to-day activities of the school. Each teacher is assigned to a class and teaches all the subjects of that class except French. However, as of the last term before data collection ended, the school started trying out a system of subject teaching

so that teachers specialized in areas such as mathematics, English and science can teach other classes besides theirs.

SNPS exemplifies a government school in Ghana. Fees are not paid but small levies are usually collected through the PTA for some developmental projects and infrastructure in the school. Admission to the school is usually the sole decision of the head teacher:

It was a blazing hot day with dry winds blowing dust from the uneven and sandy school compound. We used our hands to shield our faces from the dust. The head teacher complained about the struggle with the dust at this time of the year coupled with the heat. Just then a woman with a baby strapped to her back walked towards us and as she approached us there was a smile across her face. She greeted and the head teacher asked why she didn't use an umbrella to protect the baby from the scorching sun. She explained that she did not anticipate it at this time of the day. She proceeded to tell the head teacher that she had a little problem but that it was brief, and he gave her the go-ahead to tell him what it was. She explained that she wanted to bring her first two children to the school the following term. When asked where the children are schooling she mentioned the name of a private school. The head teacher asked why she would then bring them here, and she responded that she could no longer afford the school fees. He offered his sympathies and added that times are tough these days. He told her to remind him at the beginning of the new term so that he will see what can be done for her. (Field notes, 19th October 2016).

Further, the school is run through directives from the education directorate under whose jurisdiction the school resides.

3.4.1 The physical environment of the school

The school is made up of three long blocks arranged in L-shape with twelve classrooms. In front of one of the blocks is a water reservoir for harvesting rainwater. Besides the reservoir is a tippy tap for hand washing. It is a hands-free way to wash hands with soap. The water is usually stored in a medium-sized gallon and operated by a foot lever and while you wash your hands, the water sinks back into the ground.

In front of the water reservoir is a vast field. This field is sandy and rocky. When it rains, deep gullies are formed and so the terrain is uneven. The area serves as a football field for the school, and the boys usually play football there during break. There are a few trees scattered around the school compound. Some of the teachers park their car under the trees closest to the classroom block. There is also a food market within the compound where a group of women sell food, sweets and fruit to the children. Foods sold at the market include rice and beans with stew, boiled beans with grated cassava, fried yam with pepper, and fish and corn dumpling (Kenkey).

3.4.2 The classrooms

As indicated earlier, there are twelve classrooms for the primary school. In each of the rooms, two and in some cases three children share a wooden desk. Each class has a blackboard with chalk for writing on it. At the entrance of the classroom is a table and chair for the class teacher. On the teacher's table are exercise books, the class register and a cane. Each teacher sits at their station in the classroom to mark the class register or correct class exercises. When the teacher is not seated, he or she is standing in front of the class teaching.

The classes have windows created from hollow, square-shaped concrete blocks. The finished work is thus an extended number of holes on the upper part of the wall, which serve as a source of ventilation. Each room has two doors: one opens to the front veranda and another to the back veranda of the block. The doors are usually left open. Some of the floors of the classes are unevenly cemented with cracks and sand. The classes are often strewn with broomsticks because

the children carry brooms to sweep at school and they store these brooms at the back of the class.

On the walls of most of the classrooms there is writing in either chalk or charcoal. Some of the writing is incoherent while some is quite legible. At the back of each class there is a cupboard where the teacher stores the children's textbooks and other readers.

3.4.3 The head teacher's office

The head teacher's office is a small room with limited space. Inside the office is a table and chair and a worn out sofa. On the table is an attendance register that teachers sign every morning when they arrive. There is also a TV on top of a cupboard attached to the wall. The television is mostly on in the morning. On the wall of the office are calendars from 2013 to 2017, as well as a clock, a Pupils Attendance chart, a Submission of Lesson Plan chart, a school master timetable, a school enrolment chart, a duty roster for teachers and the programme for the term. The school drum, which is played for the children to march into their class, is stored here.

Behind the head teacher's seat is a desktop computer and a printer and close to it is a refrigerator. On top of the refrigerator is a medium-sized statue of Jesus. The school first aid box is kept on the floor beside the head teacher's chair. Inside the container is a piece of cotton wool and piece of gauze stained with Gentian Violet.

Any visitor to the school is received in the head teacher's office. Sometimes brief meetings with teachers are held at the entrance of the office. Parents who come to pay levies do so in there, and the levies are received by the head teacher. The children hardly enter the office unless to pick up the drum or to pay their levies on behalf of their parents. There is one girl designated as the 'office girl' who cleans the office, is sent to buy food for the head teacher and washes the bowl or plate used by the head. Morning assembly is conducted in the space below the front of the office.

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There is no staff common room at SNPS and so the teachers interact at the entrance of their classes or under the trees in front of the school block. The other space they use is a room called the 'Resource Centre'. However there are just a few long wooden benches and a table in that room and so it is often empty. Often one particular teacher sits there to correct assignments. It is also used during the end of term exams to seat some of the children when taking the examinations.

3.4.4 A typical school day at SNPS

School usually starts between 6.45 am and 7 am for most of the children. They clean the school compound and sweep their classrooms before the morning assembly at 7.45 am. In the dry season the whole compound is filled with dust as the children sweep the ground with brooms. After this the bell is rung by a boy assigned to keep the time. The children run to the assembly ground and form lines according to their classes. The girls are in front while the boys remain at the back. Those arriving at this time can always be certain they will be beaten with a cane by the teacher on duty. Others who make noise during the assembly are made to kneel on the bare ground with their hands raised. They stay in that position until the assembly is over.

The children say the Lord's Prayer, recite the national pledge and sing the national anthem. After this they sing a marching song while the drums are played and they march into their various classes starting from the lower classes to the upper classes. Classes begin at 8 am and they run the same schedule as BPS. However, the school day ends at 1.45 pm for SNPS and all the children depart from the school premises. Extra tuition is not held for the children. Besides having to gain approval from the education directorate to do this, it involves money which many parents are reluctant to pay or unable to afford, as indicated by the head teacher.

Beside academic work, the school also celebrates 'Our Day'. They rearrange their desks so that they can sit together with their classmates to have special meals that they bring from home or buy. However, no entertainment is held like in BPS and they are all expected to come to school in their school uniforms. For those

who are unable to bring special meals, they usually skip school on the last day of the term. For this reason the school authorities often ensure that the children are given their report cards a day before the last day of school.

3.5 Conclusion

In this chapter I have provided a descriptive profile of the two schools and the municipality in which they are located. This helps to give first-hand information about the physical and social environments of the two schools. Although located within the same municipality, the features highlighted show that the two schools differ in terms of physical infrastructure, human resources, organization and the overall arrangement of social life within the school. It is also apparent that the backgrounds of the children who occupy these schools differ. While children from BPS pay higher school levies and so have the choice of extra tuition time in school, children from SNPS participate in school following what policy the government sector allows and provides for. There are thus differences in the social lives of these children, which means these two schools provide useful profiles to explore the nature and depth of interactions between children and adults. Also the extent to which these social situations and interactions allow for children's agency in their illness experiences through their everyday interactions will be relevant within these spaces. In the next chapter, the procedure and processes for collecting data in this regard are detailed.

4

Research methods

4.1 Introduction

This chapter outlines the approaches to collecting data in the field. First, I briefly discuss the research orientation that guided the collection of data and in turn influenced the choice of various data collection techniques used. Following this, I focus on how the field site and participants were selected. I then highlight how access to the field was gained. Further, each technique that was used in eliciting data is discussed. A reflection on my position in the field and how this either enabled or created difficulties is examined. I then list the ethical issues arising from the study and how they were managed in order not to harm participants.

4.2 A consideration of the research orientation

As discussed in earlier chapters, there has been a paradigm shift from looking at children as natural, passive, incompetent, incomplete and incapable of making sense of their own lives (James and Prout, 1997; James and James 2004). Along with considering children as competent and active agents in social life, it has been advocated that research that seeks to understand the lives of children from their own perspective must directly involve children. Thus children must be seen as subjects rather than objects of research (Christensen and James, 2000). In this way contemporary sociological works on children's lives have been drawn to qualitative research methods that pay attention to bringing out children's own perspectives rather than learning about their lives through the eyes of others (Mayall, 1993; James, Jenks and Prout 1998; Brady et al. 2015; Jenkins 2015).

Qualitative research methods have been advocated as particularly useful to study children and their lived experiences. This allows the use of participatory methods of research as a way to address power relations inherent in the research process as well as interactionist analysis that subjects aspects of everyday life to detailed and critical reflection (James et al. 1998; Jenkins 2015). By focusing on this kind of strategy to elicit data, less attention is paid to verifying the 'facts' or 'truth' of the story and instead on the meaning an experience has for a child and how children understand themselves and their relationships with other social actors (Holland et al., 2010). Relying then on this paradigm put forward by James

and Prout (1997), this study views children as social actors whose perspectives about their lives and health experiences are invaluable to understanding their lived experiences. I therefore relied on methods that gave them a direct voice.

To achieve this, a qualitative case study approach was adopted. This is because the study sought to explore a phenomenon within its context using a variety of data sources (Yin, 2003). The study focused on children's everyday interactions with parents, teachers and peers in the home and at school. As Prout (1986) and Mayall (1993, 1998) observe, the home and school are the key structuring institutions of children's social obligations. These are spaces in which children are trained and equipped with the expected behaviour and norms of wider society. Paying attention to these two spaces enables an understanding of children's position within them and what role this plays in shaping their interactions with the adults that make up these spaces in relation to their illness experiences.

4.3 Selecting the field and participants

Although the study's focus is on the home and school, no home was selected. At the preparatory stage of this study, I proposed to gather data from the homes of children engaged in the study. This was however not possible because I encountered some difficulties recruiting parents and they ultimately reserve the right to permit me into their homes or not. So the data gathered about the home is based on accounts, narratives and descriptions from children and parents who participated in the study.

Two primary schools were selected to take part. These were purposively selected based on two criteria: social class and my personal experience in these two schools. By social class, I considered one school that reflected a largely middle class status and one that reflected a largely working class status in order to make a comparison. That is, the middle class school reflected the main characteristics of a typical school a middle class family in Ghana would choose. These characteristics include being private, payment of school fees (because education within government-established and -managed schools are free at primary level and more recently up to the senior high school level), small

class sizes, different style of uniform from the usual ones recommended for state schools in Ghana, and some extracurricular school activities not offered in government-owned schools. On the other hand, a school that mirrors a typical school working class families would send their children to is a government-managed school, with large class sizes, uniform prescribed by the government, no school fees being paid and no extra time spent in school outside the stipulated school hours. These criteria were informed by Lareau's (2002) assertion that some aspects of child-adult interactions and the outcomes they produce for children's lives are influenced by social class.

The second criterion was based on my personal experience as a child in both of these schools. I attended both of these schools for my primary education in Ghana. I opted for my former schools as a way to help me reflect on and be able to immerse myself in the everyday experiences of the children. Also my experiences as a child within the two distinctive styles of schooling (private and state) informed my assumptions surrounding this research and so these schools presented spaces for me that could be used as samples to elicit the experiences of children in relation to their illness through everyday interactions with adults.

This study focuses on children between the ages of 7 and 11. This was largely the age group found in the primary schools. Observations of ongoing interactions between teachers and children focused on this age group. However, when interviews, class interactions and focus group discussions were introduced, I focused on ten and eleven year olds. This was done with guidance from Prout's (1988) observation that a little sense of the difference in the meaning of sickness is acquired from children of different ages. Also, because the collection of data lasted about a year, some of the children who were nine or ten years old became a year older and even moved classes.

In as much as my focus was on the views of children, parents and teachers were also engaged to elicit their views. This is because children are constantly interacting and having relations with adults, in this case teachers and parents, as part of social processes. As Mayall (2015) points out, individuals or groups are better understood from identifying and analyzing the relationships between

and among them. It is only reasonable then to get a complete story through all the participants in the everyday lives of children.

4.4 The fieldwork

My initial entry into the field was through the Sagnarigu Municipal Education Directorate after presenting an introductory letter from the Amsterdam Institute for Social Science Research (AISSR) which spelt out who I was and the purpose and scope of my research. In addition, I made available an ethical clearance letter from the same institute and provided the directorate with copies for future references. I also introduced myself personally and had the opportunity to meet with the director himself to make my intentions known. After this, the director introduced me to the office in charge of such matters and I was issued with a letter addressed to the head teachers of each of the schools to grant me access and the necessary assistance to facilitate the study.

Arriving at the two schools was a mix of nostalgia and surprise at how most things and routines remained the same. At BPS I met with the head teacher and introduced myself and the purpose of my study. I also mentioned to him that I was a former pupil of the school. He was happy to hear that. He directed me to the assistant head teacher after he had read and filed my letter from the directorate. From then on all matters concerning the study were handled and directed by the assistant head teacher. There were some teaching and non-teaching staff from my time as a pupil. I was welcomed with open arms and showed off to the children as a former member of the school who was now studying for a PhD and had done them an honour to choose to undertake my research in the school. Here, I was first introduced to the children and made to tell them the purpose of my study and what it was all about, and then later to the teachers. This initial encounter allowed me to notice some salient issues surrounding the study. That is, my expectations and assumptions based on my knowledge of hierarchical relations between adults and children in Ghana were questioned. I had expected the usual introduction to the (adult) teachers and then later to the children. It was thus an exciting and insightful start for me.

In the second school (SNPS) I presented my letter from the education directorate and introduced myself to the head teacher who in turn introduced me to the teachers. It was after this I was then introduced to the children. Here, all the teachers were different from those who taught me when I was there. All the same, the teachers expressed happiness that I had gone through that school. I went from class to class with the head teacher to introduce myself and to explain to the children why I was there. The head teacher here dealt with all matters relating to the study and all my activities in the school during data collection.

In both schools, I was allowed to explain the study to the children. As said, at BPS this was done first to the children and then the teachers, and at SNPS it was the reverse. When I explained the study to the children, some of them did not understand why I wanted to speak to them. Others did not understand what the research meant and why I was doing it. I had to come up with a way to explain this to them so that they fully understood what my study was about before consenting to take part. I owed it to them to make things clear at the onset so that I did not take undue advantage of them because I am an adult, and to allow them the freedom of choice. In this way, I used the metaphor of homework to explain my work. I told them that just like they were in school studying, I was also in school studying. I added that as they are given homework to take home and bring back the next day, my teachers at my school had also given me homework. My homework was to find out if they have ever felt unwell and what they did or their parents and teachers did for them. At this point, in both schools, some of the children already started pointing out that they remembered a time when they were sick (they used the word sick). I believe that this explanation served to clarify for the children exactly what I was going to engage them in.

However, with this explanation, some of the children in both schools thought I was a medical professional and so began to ask me if I was a doctor. I immediately let them know that I am not a medical professional (doctor, nurse, pharmacist). Nevertheless, some children ran up to me during break time and asked about symptoms their friends diagnosed as a particular medical condition to find out if the diagnosis was correct. This was also another point of surprise to me: the children did not know me but were quick to open up to me and to ask

about sensations of not feeling well. It was also a relief for me, as in the back of my mind I had questioned the possibility of eliciting data about illness from a rather healthy population. However, this was already proof that I would be able to gather such data.

Further, I initially asked the children to refer to me by my first name as a way to break any hierarchies or power relations. However, no single child did this. It was not surprising as in interactions in Ghana adults are addressed by their titles not only by children but also people who are in subordinate positions to them. I did not force this on the children as it was a bit confusing for them. I allowed them to refer to me as 'Madam Colette' so as not to disrupt their space and way of doing things.

Fieldwork began in June 2016. However, not much could be done in the first months as by the last week of July the schools went on vacation. Most schools in Ghana have three terms a year with breaks in December, April and July. The breaks in December and April usually last between twenty-five days and one month as the dates are not fixed and keep changing each year. The break in July is however the longest and spans a period of two months. Thus taking into consideration the breaks and months in which data was collected it covered a period of twelve months. During times when the children were preparing for and taking examinations before the break, I did not actively engage them. It was also usually a busy time for teachers who had to conduct exams, mark exam scripts and complete the children's continuous assessments forms. However, I 'hung around' and observed activities in the schools. Thus data collection was not a continuous process but was scheduled around the way in which the school year was organized. For the period of collecting data the school schedule was as follows (the 2016/2017 academic year): 13th September to 15th December 2016, first term; 10th January to 13th April 2017, second term; and 9th May to 27th July 2017, third term. The first term of the new academic year (2017/18) was from 12th September to 14th December 2017. On 14th December 2017, when the schools closed for the holidays, my fieldwork ended.

During the fieldwork, I spent four out of five days in the week in the schools. Out of that, two days were spent in each week in each school. I did not assign fixed days to each school but ensured that by the end of data collection I had spent each day of the week in each school. I reserved one day of the week to write field notes, reflect, strategize and reorganize my data in order to pursue emerging issues and to allow the data to guide my next steps. This day was also not fixed. There were days I spent the whole school day at the schools and other times I stayed till midday. I used these criteria in order to capture the daily routines as much as possible and to be able to locate interactions surrounding illness experiences in these routines. In addition, the English language was used in all my interactions with participants as it was the language they were all conversant in and found easiest to express themselves in. In what follows, I outline the techniques that I employed to elicit data.

4.5 Data Collection Techniques

It has been pointed out that the stance or perception a researcher has about children influences the methods that are adopted to study them (Thomas and O’Kane, 1998; Holland et al., 2010; Hunleth, 2011). At the same time using ‘adult’ research methods such as participant observation and interviews allows children to be treated like adults and allows their competencies to be tested (Punch, 2002). A combination of ‘child friendly’ and ‘adult’ methods ensures children are not patronized and creates a balance (Punch, 2002). Also the use of innovative techniques such as task-based methods comes in handy to help children to feel more comfortable with an adult researcher (Punch, 2002). The study drew on this line of thought by employing a number of techniques since it is premised on the belief that children are competent actors in their illness experiences. These techniques gave children a direct voice and were also suited to the children’s context, competence, knowledge and interests. A triangulation of techniques was therefore used, which according to Denzin and Lincoln (2000) exposes diverse aspects of empirical data and allows for the weaknesses of each technique to be overcome by other techniques. In addition, Christiansen and James (2000) propose that in choosing a particular method of research, its appropriateness for the people involved, the social and cultural context of the

people involved as well as the research questions the study poses should be considered. I present a summary of the techniques which proved appropriate within the context of the study in Table 1 below and then discuss each in detail.

Table 1. Summary of Data Collection Techniques

Technique	Specific details	Remarks
Observations / Participant Observations of - Classroom interactions - Playground/break time interactions - Music and dance lessons - Physical environment of classrooms and the school as a whole - 'Our day' activities - Children's interactions with parents at the end of the school day	- Classroom interactions lasted 45 minutes (6 scenarios) - Each playground or break time interaction lasted between 10 to 30 minutes (10 specific scenarios) - Music and dance lessons lasted 45 minutes (4 lessons) - Physical environment of the school was a continuous process till the end of data collection - 'Our day' activities: Observations lasted an hour to an hour and half (2 'our days' observed in both schools). - Children's interactions with parents were usually from 5 minutes up to 20 minutes depending on the time they spent together on the school premises before departing (it was a continuous process with 10 scenarios specifically documented).	These were to help observe the nature of the relationships and level of interactions between children and teachers, children and their peers as well as children and parents. Observations were recorded in field notes.
Classroom interactions with children	5 interaction sessions in both schools (3 at SNPS and 2 at BPS)	This was done based on the willingness of the school authorities to grant access to the children in the classroom. Information gathered here was either written on the black/whiteboard, and photos were taken of them at the end of the session, or some children were selected to take down notes as we discussed as well as recording these interactions in field notes.

Table 1. (continued)

Technique	Specific details	Remarks
Essay Writing	40 essays gathered from BPS	Allowed children to write about their illness experiences
Focus Group Discussions with children	10 discussions in total (four in BPS and six in SNPS)	Groups of between 8 and 12 children with each group made up of either only boys or only girls. Some discussions were tape recorded, children took notes of some discussions as well as recording in field notes
In-depth interviews with children	20 in total (10 in each school)	These interviews were tape recorded as well as written in field notes. Lasted between 10 minutes and 38 minutes
Focus Group Discussions with teachers	3 FGDs in total (2 at BPS and 1 at SNPS)	Groups of between 4 and 6 teachers
Informal discussions with groups of mothers	2 discussions with: 1. 2 mothers 2. 3 mothers	These were done while mothers waited to pick up their children from school.
Informal conversations with individual parents	2 mothers and 2 fathers	Done with parents waiting to pick their children from school
Interaction with two teachers in charge of health	1 teacher from each school	

4.5.1 Observations/Participant Observations

Christiansen and James (2000) have made the case that forming relationships with children while working with them is essential as it will make children want to continue to participate in the research process. Thus, in my first encounters, I was just present in the everyday activities of the children at school. This was to help me in the beginning not only to acquaint myself with the daily routines of the children but also for the children to get used to my presence. I did this by sitting in their classes with them during lessons, joining them in the playground at break time, participating in 'our day' (last day of the term) celebrations, and waiting around with them at the end of the school day for parents to pick them up. I also participated in music and dance lessons and joined the children to have lunch. Further, observations were made of incidents of children complaining about feeling unwell to teachers as well as presenting cuts and bruises obtained on the playground.

Not only was this process a starting point for me but also, throughout the study, it was my way of grasping the nature of relationships and interactions among the children, between the children and teachers, between children and parents and between teachers and parents. I was also able to take into consideration the physical environment of the schools and how this enabled or hindered interactions in general and those related to illness in particular.

Although in the beginning the children and teachers were constantly aware of my presence and so often modified their activities, over time my presence was a daily occurrence to them and they became oblivious to it. Observations were scheduled around activities in the school, recorded in field notes and served as guidelines for directing other techniques used.

4.5.2 Classroom interactions with children

From observing the children, I was allowed to directly engage them in classroom encounters. Using the style of the teachers in the two schools but with some modifications, I discussed their illness experiences. Unlike their usual class style, I made them aware that they did not have to participate if they did not want to, they were not required to raise their hands to answer a question, and

there was no wrong or right answer. Further, I asked the class to pick one person to write down the things we discussed, and usually they unanimously picked someone they said had good handwriting to serve as what they called 'secretary'. In addition, one person was picked by the class to write responses on the board. This helped us all to check responses and clarify answers that they gave. It was also a way to aid the 'secretary' to write.

This technique helped in the beginning to create an understanding among us of concepts such as 'feeling unwell' and 'not feeling well'. There was also the introduction of vignettes with the children at this point in order to find words and descriptions surrounding feeling unwell. This is because the study did not make use of any named disease or diagnosed medical category. In this way the children acted as co-researchers in order to define the scope of the study based on their understanding and perspective.

Within these discussions, I made use of a checklist I created based on the research questions to facilitate the process. For instance, children were asked to list sensations they considered as feelings of being unwell. They were also asked to talk about and to list common illness categories they had experienced within one month. Furthermore, children named the adults to whom they were likely to report not feeling well in the context of the home and the school through listing and sorting them in order of importance. While this criterion required counting and numbers, I only used it as a way to get the general pattern of children's responses. What I prioritized were the reasons children gave for the path they chose. In addition, the children listed strategies they employed in dealing with feeling unwell. Children were also asked to talk about their daily routines at home. This enabled me to get a general idea of their backgrounds and how their lives are organized outside of the school setting.

This was done in the larger class setting—sometimes a class had about sixty children—and so it presented the children with their usual class situation, but at the same time they were not restricted in what they could or could not say. Many children actively participated in these sessions and when the time allocated was over most of them did not want to end the discussion. These sessions lasted the

duration of the normal class time of forty-five minutes. As pointed out earlier, the children recorded these encounters through a 'secretary' they unanimously selected. They also wrote on the board after which I took photos of what had been written and also recorded happenings in my field notes.

4.5.3 Essay Writing

It has been observed that essay writing is one of the most suitable approaches for children to visualize health and to reveal how they understand illness and communicate their experiences (Horstman et al., 2008). Through observations and classroom interactions I got to know early on the children's strengths with the techniques. This informed my decision to only get BPS pupils to write an essay on the topic 'A time I was feeling unwell'. I provided the children in class five of BPS with exercise books and they were asked to write an essay on the topic listed. They were given guidelines to write about a time that they had felt unwell—this could be within two weeks to three months, depending on what they felt comfortable with. There were some children from class six who were also interested in writing the essay and so I allowed them to. They were given a period of two weeks to write the essays and they were allowed to take the books home. This was to ensure that it did not interfere with their homework schedules and also to not put undue pressure on them to return the essays.

Overall, forty essays were received, from forty-seven books that were given out. Some children provided descriptions which helped me to have a glimpse into their illness experience. Others were not really able to write much about their experience but they provided some ideas about how they made sense of feeling unwell. Although not separated or sectioned, the majority of the children gave a sequence of events leading from when they started feeling unwell to what they did or was done for them by the adult they reported to. Some of the issues arising from the essays were used in framing questions for focus group discussions and in-depth interviews. Initially I had suggested to the children to write their names on the books so that I could follow up on salient issues. However, one of the children, a girl, pointed out that their friends would take their books and make fun of them. The nodding in approval that came from her classmates, especially the girls, was evidence that most of them did not want their names

on their books. They were therefore given the choice to either write their names on the books they were given or not.

4.5.4 Focus Group Discussions with children

In groups of between eight and twelve, we took our discussions outside of the classroom. In selecting the children for focus group discussions, the following was important: the children were members of the same class and so roughly the same age group; the children were willing to participate; and the children had shown a keen interest and active participation in previous encounters. The discussions were done in groups of only boys and girls to provide some form of homogeneity. The criteria were also used as a way to bring together children who are familiar with each as it makes them more powerful and relaxed in the company of their peers (Einarsdottir, 2007; Mayall, 1993).

I used a guide to start and steer the discussions. These included questions and vignettes created through information gathered in the previous interactions with them. Through vignettes, the children were presented with various hypothetical situations of illness experiences and allowed to give names to them in their own understanding and words (Akello, 2010).

The discussions were held outside of the class. In the case of BPS, we sat under the shade of some of the trees and at SNPS we used the resource unit. We arranged our seats and sat in a circle so everyone could see each other, and so I did not have to take a seat in front of them like in the classroom, thereby minimizing power relations. They usually lasted between forty-five minutes and one hour.

Some of the discussions were recorded with permission from the children but at some points, when I realized that the recorder made some of the children timid and unwilling to speak up, I switched it off and resorted to note taking. Just like in the classroom encounters, the children usually selected one person to take notes. Everyone was given the opportunity to speak and ask questions when others' views were not clear to them. At the end of each session, I usually gathered the main points and confirmed with them that these were indeed a

reflection of their ideas. It was also a way for me not to assume anything but to gain understanding from their point of view.

4.5.5 In-depth interviews with children

While engaging the children in class discussions and FGDs, there were some children who usually had a lot more to say but were restricted by time and their classmates' attempts to give their views. These children were noted. Also I made a request to the children to volunteer to take part in a one-on-one interview session with me. This was to ensure that I did not discriminate against any child in the participation process. It was however not an easy process as many children wanted to be interviewed. I recruited all these children but as the process began some could not find the time between classes to give the interviews and did not have any other time options. Others also later declined to participate because they were torn between the interview and making preparations for the 'our day' celebrations and they chose the latter. This helped to reduce the numbers. In the end ten children were interviewed in each school, so twenty children in all. Of this number, three were boys and seven were girls at BPS, while five boys and five girls participated at SNPS.

I used an unstructured interview guide that reflected the research questions but allowed children's responses to steer the conversation. The children gave retrospective accounts of how they made sense of a feeling of ill health in the past and how it was dealt with. They recounted their experiences through a two-week to one-month recall or timeframe that worked best for the child. Through these narratives it was then possible to locate where and how illness negotiations take place.

The longest interview lasted thirty-eight minutes and the shortest ten minutes. All the interviews were tape recorded with permission from the children. They were also held in places on the school compound that the children chose and felt comfortable in. This allowed for in-depth sharing of experiences relating to illness at home and school by the children who would not have shared these in group situations.

4.5.6 Focus group discussions with teachers

As a way to include the voices of the adults that children interact with, teachers were engaged in focus group discussions. This was done in groups of four to six teachers. The criterion for selecting the teachers was their willingness to take part in the discussions. The discussion was held in the staff common room and summer hut for BPS and under the shade of a tree at SNPS. At BPS, one FGD was held for female teachers and another for male teachers, while in SNPS only one FGD was held for both male and female teachers. The FGDs were scheduled at different times within the period of collecting data based on the teachers' schedules and availability. In both schools the teachers declined to have the interviews recorded on tape and so I resorted to note taking. I used a guide to start the discussions and allowed the teachers to steer the process with their views, only intervening to clarify issues when necessary. The FGDs lasted between sixty and seventy-five minutes.

This helped to obtain the teachers' views about the children, how those views foster the kind of relations and interactions they have with the children and ultimately how this plays out in the children's illness experiences.

4.5.7 Informal conversations with groups of parents and individual parents

In the initial preparation for the study, I proposed to include parents in the data collection process. This however proved more difficult than I had envisioned. Formal agreements to meet with and have interviews with parents were often postponed and never followed through. Some of the children had pointed out to me that their parents were busy and may not be able to grant me interviews. To overcome this, I resorted to waiting around with the children at the end of the school day and engaged parents who were willing to talk in conversations. I therefore refer to these encounters as informal conversations because they were unplanned.

When I used this approach, in the first instance I asked permission to tape-record conversations but the parents stated that they did not have time. In my subsequent encounters I did not even suggest it and this yielded some results.

I was able to engage them in conversations lasting between thirty five to fifty minutes. These parents were mainly mothers. The conversations comprised two groups of mothers, two individual mothers and two individual fathers. The conversations were around parents' views of their children as well as retrospective accounts of dealing with children's complaints of feeling unwell.

This engagement proved useful as parents' views about their children in relation to their illness complaints were unearthed. Ways in which parents dealt with and negotiated their children's complaints were also relayed. The approach was however only useful in one school, BPS, as many parents pick up their children daily. It was not possible at SNPS as this is not the case and so no parents were interacted with there. Parents' views presented for SNPS are based on narratives, recounts and the views of the children about their parents. In some instances, these corroborated with some of the issues raised by the parents I interacted with at BPS.

4.5.8 Interview/interaction with two teachers in charge of health

I refer to teachers in charge of health although each school did not specifically name a teacher as such. At BPS, the deputy head teacher acted in such capacity while the head teacher did so at SNPS. These teachers were interviewed on the general set up of the school as well as the specific issues relating to health. Their contributions helped to understand how the schools work and the resources available to them that shape how children's illness complaints are dealt with.

4.6 Data Analysis

Data collection and analysis occurred simultaneously. This was to ensure that emerging highlights were clarified by participants and to direct the next steps of data collection. Thus, a form of what Cresswell and Miller (2000) describe as 'member checking' was employed. At every stage of the data collection the children were presented with data interpretations to confirm and clarify meanings and words as a way of ensuring that the findings are reliable and truly reflect the interpretations that they have of their experiences. Further, different approaches to collecting data (observation, classroom interactions,

essay writing, focus group discussions and in-depth interviews) were used which allowed for triangulation to ensure that meanings could be clarified, and that shortfalls in one approach could be overcome by other approaches.

Interviews and some FGDs were audio recorded and transcribed verbatim. That is, I maintain the language as used by the children and other participants in our interactions. The rest of my encounters with participants were hand written in a field notebook. There were also notes taken by the children as well as photos I took of notes written on the board in the classroom. These notes were often rewritten immediately after I left the field as a way to continue to be immersed in my encounter with my research participants and not lose out on vital information.

When analyzing the data, the process was guided by Hsieh and Shannon's (2005) approach to conventional content analysis of qualitative data related to human experience of health and illness. Following this approach, I was able to begin to manually assign codes to transcripts through continuous reading and re-reading of field notes and transcripts as the study progressed. This allowed me to be fully immersed in and tuned in with the data. The codes were generated using words and phrases that represented attributes (such as the gender of the participants), emotions (demeanour and reactions of participants) and the participants' own words. Initial thoughts and impressions of the data were laid out and often discussed with one of my supervisors while I was still in the field. Words emerging directly from the transcripts that were reflective of the key thoughts and ideas expressed in participants' responses became labels for codes. Further, the codes were sorted into categories based on their relationship with, as well as their frequency and consistency to, the research questions. Once this was done, they were then categorized under underlying dominant themes that addressed the research questions. These themes were noted and discussed with my supervisors at the end of the fieldwork.

In writing the analysis chapters of the thesis, these themes mainly shape the chapter titles and sections presented. I discuss them in relation to the relevant literature engaged with in this work and also with the theoretical concepts that have been used. This allows me to compare and to contrast my findings, as

well as to highlight my contributions to the research field (Hsieh and Shannon, 2005). Further, I reproduce the responses of participants captured in the field notes and transcripts to support assertions, suggestions and arguments I make in these chapters as a way of heavily relying on the voices of my participants and privileging their perspective.

4.7 My position within the field

I went into the field mainly considered an insider by my research participants. This is because I am a former pupil of the two schools and I am also a Ghanaian and live within the municipality where the schools are located. I am therefore familiar with the context in which the study is set. This position facilitated my entry into the field. As mentioned earlier, there were still some teachers in one of the schools who taught me while I was there. The authorities thus had a softened attitude towards me as they considered me one of their own.

In addition, as a former pupil, the children saw and identified with me as having gone through what they are going through and so as someone who would understand them more. Once I had been exposed to the routines of the schools, which had not changed much in all these years, it helped me immerse myself in their daily routines and to reflect on the children's experiences from what I experienced as a child in those schools. I was able to grasp in detail what the children told me and also what I observed. For instance, with the caning of children in school, when I left one of the schools for the other as a child, it was rumoured among my peers that I could not stand the beatings and that made me move. Whether their rumour was true or not, I could find myself in some of the children who were timid and afraid of some teachers because of caning, and this had an influence on the nature of interactions between them and the teachers. I however consciously checked with the children about the meanings they attached to their experiences so as not to take their views for granted, just because my experiences resonated with theirs.

The position of familiarity also presented challenges. I was seen as a former pupil who had attained a high status, that is I have a master's degree and am

working towards a PhD in Europe. This view came with expectations. Some teachers asked if there was a way I could mobilize funds to renovate or build a school library and stock it with books. I was made to take pictures of the abandoned library, which is now used as a place for relaxation, just so I could show them to potential donors in my circles for assistance. Other teachers asked for information on scholarship opportunities and funding to pursue higher education. It was often overwhelming when I did not have definite answers even when I was expected to. One of the things I was able to do though as a former pupil was to act as a motivational speaker for some of the children who were about to complete their primary education and move to secondary school. I encouraged them in their endeavours and urged them to make the most of their time.

I have worked as a teacher in a private school in Ghana and this position also created both challenges and as well as fostered my interaction with the children. In dealing with the children, especially within classroom settings, there was often the temptation to act as the 'teacher' when things got out of hand. For instance, in one of my class interactions the children got rowdy and would not sit down to enable discussions. My first instinct was to pick up the cane on the teacher's table and threaten them with it as a way to gain their attention, though I had no intention to beat them. It however dawned on me that my position there was as a researcher and the children had the free will to participate or not. After calmly trying to engage them and it did not work, I interpreted it as their choice not to interact with me that day and so I respected that and left.

On the other hand, my experience as a former teacher helped me to organize the children and to effectively interact with them within the school environment. I was able to think of innovative ways to engage them and not have them lose interest in the process. In most cases, I was able to gauge interaction methods that proved useful in the past to help me interact with them without imposing myself on them as an adult.

As a female in the field, more girls were drawn to me than the boys. Whereas the girls opened up to me right from the start of data collection, it took a while in the

field before the boys engaged with me freely. However, situating FGDs towards the end of the data collection helped gain the trust of the boys, so I was able to complement earlier data gathered from them.

4.8 Ethical Issues

In situating this study within child participatory principles of social research and primarily by eliciting the views of children, ethical considerations were central to the process. Several ethical factors were considered in order not to exploit, harm or take advantage of the children and also to minimize power relations that are inherent in child-adult interactions in Ghana.

Ethical clearance and permission were granted for the study by the Ethical Review Board of the Amsterdam Institute for Social Science Research (AISSR). Following this, permission was sought from the Sagnarigu Municipal Education Directorate (then Sagnarigu District Education Directorate). This is because the two schools are under the jurisdiction of this education directorate and this represents the official body in the country that regulates these schools. Once clearance was received from this office, permission was sought from the head teachers of the schools with letters from the educational directorate as evidence of the approval of the study to be carried out in their schools. After this, I was given the opportunity to explain the purpose and scope of the research to teachers and the children and ask their permission to take part in the process.

In addition, when children were selected for the study, consent was sought from their parents through the use of informed consent forms which provided detailed information on the study. I also provided my contact details in case I needed to be contacted for further clarifications. Some parents refused to allow their children to take part in the interviews and this was respected. For those who gave consent, their children were again reminded of the purpose of the research and what it entailed, and were given the opportunity to either take part or not. All the children agreed to be a part of the research. Some of the children whose parents had refused permission insisted on wanting to take part but I could not include them. This decision was taken because it has been stressed that in

doing research with children, researchers must obtain informed consent from a range of gatekeepers such as the school authorities and parents who allow voluntary participation based on information about the nature of the research and the danger and obligations that are involved (Fargas-Malet, McSherry, Larkin and Robinson, 2010; Christensen, 1999; Mayall, 1993). In this way, there is often some form of indirect or third party acting on behalf of the child.

In seeking consent, the scope, purpose and intent of the study was stated clearly to all parties involved. They were also made to understand that they were not obliged to be part of the study and could opt out at any point. In the case of the children this was explained to them in English, which was our medium of communication. They were allowed to ask questions in instances where issues were unclear to them and I provided explanations as best as I could. Further, keeping in mind the nature of relations between adults and children in Ghana, I noticed that some of the children felt coerced to help me, an adult, to find answers to my research. To augment this, I used assent in addition to consent as a measure of inclusion or exclusion from the study (Fargas-Malet et al. 2010). That is, I paid attention to the body language, responses and facial expressions of the children to determine their willingness to take part or not.

Confidentiality of the information provided has been ensured through the use of pseudonyms for the names of the two schools and the participants in the research report to protect their identity without compromising the data as much as possible. The school times and daily schedules within the two schools have also been altered without distorting the data. This is to ensure that no recognizable trend or patterns of school life can be attributed to the schools. Thus, it has been ensured that the schools, children and other participants in the study are not recognized in the text and written reports of the study.

Also children's interviews, FGDs and classroom interactions were largely held with only the children and with little teacher interruption. In cases where teachers were within earshot, especially in large classroom interactions, topics discussed were usually those the children freely talked about such as disease categories they are familiar with. However, researchers working with children are cautioned

not to explicitly promise confidentiality as it may not always be possible when a need arises to pass on information to a third party in order to protect the child (Raffety, 2015; Williams and Rogers, 2014; Christensen and Prout, 2002). In taking a decision such as this, the interest, safety and wellbeing of the children were paramount while at the same time acknowledging the obligation not to betray the confidentiality of the participants.

Participatory research often requires close and long-term relationships with research participants, and when children are involved, this relationship becomes complicated (Einarsdottir, 2007). This is as a result of the potential power relations between an adult researcher and the child participant stemming from age, status, competency and experience (Hunleth, 2011; Thomas and O’Kane, 1998; Punch, 2002; Mayall, 1993). Also Punch (2002) states that children may not be used to expressing their views freely or have their views taken seriously in an adult-dominated society and so this may be a challenge in eliciting their views on their experiences. This was observed in the field, as some children’s initial reaction was surprise. To minimize this, the study used a combination of child-friendly methods and techniques (classroom interactions, focus group discussions, essay writing, vignettes), which built on the children’s competences and experience rather than making them feel inadequate (Punch, 2002; Einarsdottir, 2007).

The study was also conducted in the context of the school, which is an environment the children are familiar with. It is also a space where the children spend most of their time (about nine out of twelve months in a year and eight or more hours a day). However, this space is largely dominated by adult authority, such as putting pressure on children to provide ‘correct’ answers in the classroom setting. This was minimized by assuring children that there were no right or wrong answers. Time was also spent with children during their lunchtime, playtime and sporting activities so that they were relaxed and in their natural environment when interacting with me.

Doing research in general often entails many ethical dilemmas. These are even more complicated when it involves children, who are considered more vulnerable

and largely guided by adults. It may however not be possible to understand the life of children within their particular context and to know the extent to which they are capable of decision making without involving them directly in research. Nuanced health interventions for children that address health issues directly affecting children can draw from research such as this in order to adequately meet the needs of children. Further, studies such as this have a potential to offer a bottom-up approach to healthcare that may be beneficial to children.

4.9 Conclusion

The data collection methods used in this study largely fell within the recommendations of the paradigm that views children as competent and active participants in their lives. Methods that rely on their own voices were therefore privileged. This chapter detailed the data collection techniques that allowed data to be gathered directly from children. The fieldwork process, the analysis as well as a reflection on the process of collecting data have also been outlined. In addition, the ethical issues encountered and how they have been managed have been discussed. In the following chapters, attention is drawn to the findings and issues arising from the data in relation to the research questions.

5

**From vagueness to a health complaint:
How children make sense of not feeling
well and seek help**

5.1 Introduction

In this chapter I address the first research question of the study: How are perceived sensations of feeling unwell actively constructed and dealt with by children in everyday interactions? By using 'feeling unwell' I refer to painful physical bodily sensations that can easily be pointed out or described. The focus of the chapter is to present how children come to know that they are unwell, the common health complaints that they are confronted with, and what they do to deal with not feeling well. The emic perspectives of the children's experiences are given priority and the kinds of meaning they make about their experiences are largely privileged. This therefore does not include diagnosis by a health care professional or from adults with whom children are constantly interacting with. It was envisioned that this endeavour would give an insight into what children do by themselves as well as offering an understanding of the health experiences of the children and the strategies they employ to make sense of these experiences. Data presented in this chapter was primarily obtained through focus group discussions, classroom interaction, essay writing and in-depth interviews with school children between the ages of nine and eleven years old.

5.2 Feeling unwell: The physical body and pain

When children were asked whether they have felt unwell before, there was always a chorus of yes. When asked what it meant for them to feel unwell they typically said that *'it is when you are not healthy'*, *'when there is something wrong with your body'*, *'when you are weak'*, *'when you are not active'*, *'when you are not able to do things because some part of your body is paining'* and *'when you feel pain in your body'*. From the children's perspective, bodily sensations form their awareness of not feeling well. They rely on the physical body to form the impression that all is not well with them. Children acknowledge and complain of not feeling well when they realize something is not normal with their body or they feel pain and cannot actively participate in their routine activities. A similar observation was made by Wasike (2007) of Ugandan children's perception of fever. However his study focused on a specific category of illness (fever). He found that children relate fever with helplessness and the inability to do things and this caused them

emotions of sadness, helplessness and despair. Nowhere in the discussions and interactions with children in this present study do they connect illness with psychological or emotional feeling. All of their attention is on physical signs. At any point when emotional feelings such as sadness came up in discussions, the reasons were because of the loss of a loved one, separation of parents and not getting their way with parents, teachers or friends and not necessarily because they feel unwell. They were also quick to point out that those emotional feelings have nothing to do with feeling unwell and some even note that those are '*normal things*' that are '*part of life*' and so should not be seen or associated with illness. Thus, right from my initial encounter with the children, the concept of 'not feeling well' was clearly delineated and understood among us (the children and me).

They were also very clear in pointing out that emotional pain or feelings are not feelings that require any treatment or medical attention because they are not '*physical*'—they cannot be '*explained*' and sometimes cannot be '*described*'. For them, they would not know exactly what to say is wrong since there is nothing concrete to point to. Again, for the children, once something is not physical, it will go away by itself because '*you will not know what medicine to take for it*' anyway. This may not come as a surprise in a society where psychological and mental ailments remain a low priority (Bird et al. 2011; Doku et al. 2011). A myriad of reasons have been identified from the perspective of policy makers and religious leaders for this trend. For policy makers, Bird et al. (2011) point out that in the first place, mental health has not been largely considered a legitimate problem because of limited appreciation of its prevalence, either due to people not accessing health care facilities, or if they do, health workers lacking the skill to identify and record patients with mental health issues. Also, they note that it is not physically obvious when people suffer from a psychological disorder and so what they experience is downplayed by both healthcare providers and society. Furthermore, there are low mortality rates from mental illness, coupled with competing health and developmental priorities whose prevalence and mortality rates are higher.

For religious leaders, it is observed that they hold views, ultimately transferred to their followers, that psychological infirmities or torments of the mind are attacks

by demons while physical infirmities such as headaches are caused by biological deficiencies (Asamoah et al., 2014). Doku et al. (2011) further emphasize that mental health disease etiology among Ghanaians is intimately connected with existing beliefs and practices. Thus, in a highly superstitious society like Ghana where the unexplained is attributed to the supernatural, it is only 'logical' that mental and psychological ailments are dealt with in the supernatural (Kyei et al., 2014). This played out strongly when children were asked how they dealt with emotional and psychological feelings which are not tangible to them and cannot be described. They largely reported resorting to praying, reading the Bible, singing or listening to gospel music, deciding not to think too much about it, talking to a friend, going out to play with their friends, sleeping or not letting anyone know what they are feeling.

Some of the common bodily sensations that characterize feeling unwell referenced by the children include: headache, feeling dull, feeling weak, feeling cold even in warm weather, vomiting, persistent cough, high body temperature, loss of appetite, stomach ache and general bodily pain. These sensations could be present as a single determinant or in combination with others for children to acknowledge that they are unwell. They generally observe how long they last before deciding to seek help or not. Besides this, they determine the severity of these sensations in order to decide on the nature of help that they will rely on to feel well again. Bodily pain that lasts throughout the day and does not get better in subsequent days is paid attention to whereas bodily pain that does not go beyond a full day is not considered a problem. This is illustrated by ten-year-old Cindy:

It was Friday and when we close and went home my head was paining but I think that it's because we play in the sun when we were going home so I didn't tell my mother. Then the next day when I was sitting down my head was paining me again, and my body is paining me and I cannot do anything. My body was hot. Then I know that I am sick.

Further, for severity to be established, a combination of signs is paid attention to rather than just a single signal. For instance, children do not rely on only

a headache to conclude that what they are feeling is severe. It has to be accompanied by for example high body temperature, weakness or general bodily pains to qualify as needing urgent attention. In this way, to classify a feeling as severe, there generally needs to be a combination of bodily sensations, these sensations should be consistent over time and they should be present for a longer period of time. Ten-year-old Musah shared his experience as follows:

Me and my friends go and play ball and in the next morning when I woke up my whole body was paining me. I prepare and come to school. During break time I couldn't eat my food and I gave it to my friends. When I went home I was able to eat and I went to play football and in the morning again my body was paining. It did me like that for three days [a repetition of what he felt for three days]. The third day when I come to school my head was also paining and I couldn't eat and my body was hot. So when I went home I told my mother that I am sick.

Fadila, an eleven-year-old girl, also shared her experience in this way:

My head was aching but I didn't mind it. We went for break and my friends bought kenkey [corn dumpling served with freshly ground pepper and tomatoes with fried fish] and we ate and came to class. When I went home my head was still paining but I did not yet tell my mother because I knew that it will go away because it was just my head so I didn't mind. Then the next day when I come to school in the morning my head was still paining and I was feeling cold. So I collect a cloth from my friend because that day we are having Music and dance [the girls tie a cloth around their waist during music and dance lessons, which is why her friend had a cloth]. So I cover myself. When it was break time I went and ate 'waakye' [rice and beans with stew] and I came back to class and I started vomiting. Now I think that it is becoming serious so I go with my friend and tell Teacher S and he called my mother and my mother come and pick me home.

In Table 2, I give an illustration of a typical dynamic that children follow to establish the severity of symptoms and to determine whether need to seek help.

Table 2. Determining the Severity of a Bodily Sensation

Bodily Sensation	In combination with either one or more of the following	Length of time
Headache	General body pains, weakness, feeling hot and cold simultaneously, vomiting and high body temperature.	Lasting beyond one day even after taking a painkiller
Stomach ache	Loose stools, weakness, dizziness	Lasting beyond half a day
Loss of appetite	Feeling dull, pain in the body, feeling cold even in warm weather, high body temperature	Persistent for more than a day or two
Cough	Chest pain, bringing up mucus or phlegm from the nose and throat, high body temperature, loss of voice	Present for more than two days

Most of the children agree that the presence of a single symptom does not necessarily indicate that they are unwell; rather a combination of symptoms gives a clear indication of not feeling well. Another important sign that children look out for is high body temperature. This is just not a necessity for them but also for their parents and teachers to come to accept that they are not feeling well. An observation in one of the schools clearly indicates this:

It is midday and I am sitting under the summer hut trying to put together some of the observations I have made for the day. There are a group of about five teachers sitting about fifty metres away from me. Two are busy correcting homework and class exercises and the other three are discussing the recent proposal by the government to make all teachers take a licensing exam. They strongly express their disapproval. Just then there is some commotion between the class five and class six classrooms. We all turn our attention there. There is a girl who is sandwiched by two other girls and they are engaged in some kind of confrontation with a teacher who is sitting on the table where the small first aid container is kept. I quickly move there to check out what is going on. As I approach them I find that the girl who is sandwiched is in tears and so I ask what is going on. 'She says she is sick' the teacher tells me. I ask what is wrong. '...that her head is paining her' the teacher adds and then goes on 'but her body is not hot...madam touch her and see'. I touch her neck and forehead as I have seen done and it is cool but she looks like she is in pain and is still in tears. The teacher tells them to go back to class and that he will check on her later. (Field notes, Tamale, October 2017)

Usually when children present their complaints about not feeling well, parents or teachers touch their forehead and neck to check their temperature. Once it can be established that their body feels hot, then the child's complaint is easily accepted. In this way, the body temperature becomes a very important indicator for the child's symptoms to either assume severity or otherwise.

An interaction with nine-year-old Rafi indicates this:

R: What did you tell your mother?

Rafi: I tell my mother that my head is paining and my whole body too is paining.

R: What did she say when you told her?

Rafi: She tell me that I should go and lie down and small time [for a while] she will see. So I go and lie down.

R: After lying down did you feel okay?

Rafi: No. It was in the afternoon she say I should lie down and in the evening like 6 o'clock or mmmm...I don't remember and I wake up and I told her my head is still paining... Then she touched my head [she touches her forehead] and my neck and my body is very hot and she said yes it's true. So she call my father and tell him to buy medicine when he is coming because I am sick.

From the above, it can be deduced that the children's subjective feeling of being unwell is legitimized by fever (hot body temperature). This is a somewhat objective appraisal for the child's claims to be accepted or for the child to be taken seriously. The child thus learns what is important and what is not when labelling and categorizing their illness.

5.3 'I am not myself': Describing not feeling well

In circumstances where what a child is feeling is not obvious to the adults they interact with (teachers and parents) and their peers, it becomes apparent for the child to put what they are feeling into words. That is, from vague bodily sensations, the children use words and expressions to describe what they are feeling. Giving their feeling a name also makes it possible for them to make sense of what they are feeling and seek out treatments that correspond with whatever they decide it is they are feeling, if they resort to dealing with it by themselves. When asked how they describe what they are feeling, the following conversation with James, a ten-year-old boy, ensued:

James: I told my friend that I am basaaa

R: What did your friend say?

James: He say that what is wrong with me and I say that I don't know. It is like my whole body is paining me and when I drink water it is like bitter in my mouth.

In naming or framing the bodily sensations that they are experiencing, children rely on expressions ('basaa') which are quite common within the social context of the Ghanaian society to express 'restlessness', 'discomfort' or some sort of 'disorientation'. The children also make use of biomedical terms to make sense of what they are feeling to whomever they seek help from. In doing this, they pay more attention to parts of their physical body where they can locate the pain. They also make use of commonly known symptoms for established biomedical diseases such as diarrhoea, malaria and typhoid fever, as illustrated by one eleven-year-old girl:

I told my mother that I have malaria because my whole body was paining me and my whole body was like a pot of hot boiling water [high body temperature]. I couldn't eat anything and my head too was paining.

It becomes clear that the children pay attention to common, socially sanctioned signs of not feeling well such as high body temperature, bodily pains, headache, vomiting and loss of appetite. These signs are familiar to both the children and

the adults and make sense in interactions. Below, I list words and expressions that the children use in describing not feeling well.

Table 3. Words used to describe not feeling well

Expressions	What they seek to describe
My eyes are turning	Feeling dizzy
My head is pounding	Headache
My eyes are like they will fall	Eye infection, particularly apollo*
Something is pounding inside my head	Headache
My head or stomach is paining	Stomach ache
Half of my head is aching	Headache
I feel 'basaa'	Restlessness or discomfort that cannot be specifically located. The children are not able to exactly pinpoint what is wrong with the body but strongly believe that there is something wrong.
I am not myself	A feeling in the body that cannot be explained but you are aware that it is present.
My stomach is turning	Nausea
My head	Headache
I am feeling cold	Fever
My whole body is paining me	General body pains and weakness
I am running diarrhoea	Passing frequent watery stools, sometimes coupled with stomach ache.
I have malaria	General body pains, weakness, headache, feeling hot and cold intermittently, may or may not include vomiting, high body temperature, loss of appetite and dizziness
I am feeling some way	Not being able to point out exactly what is wrong or having the feeling all is not well with the body but cannot point out exactly what it is
I am not feeling okay	General body weakness, fatigue and pain
My stomach is pulling	Abdominal cramps during menstruation

*Apollo refers to Acute Haemorrhagic Conjunctivitis, an eye infection. It is nicknamed so because its discovery coincided with the landing of Apollo II on the moon in 1969.

Following from the first two sections of this chapter, it becomes apparent that the children are engaged not only in a process of making sense of what they are feeling but relying on the existing socio-cultural models given by adults. Although set in a different context, the findings resonate with Christiansen's (1999: 39)

observation of three aspects of an interpretative process that children engage in making sense of their illness: a) learning to distinguish illness from other events in the flow of everyday life; b) exploring their body and combining subjective experiences of it with cultural models given by adults; and c) accomplishing both of these as individuals and collectively with other children.

5.4 Common health complaints among children

Discussions so far have focused on the bodily sensations that children rely on to make a case of not feeling well. It is also clear that they combine these sensations in order to deduce the severity of what they are feeling. Attention is now turned to the common illnesses that the children indicated to have suffered from. The children were asked to first of all list the common health complaints that they had had within a one-month period. After this, for each health complaint, they were made to raise their hands and then they were counted to determine the number of people who suffered from it within that one month. It could be argued here that an approach such as the raising of hands and being counted will lead to children being influenced by their peers and friends, e.g. they may raise their hands because their friends raise theirs. However, it should be noted that this is one of the commonest ways in which children's opinions are sought in the school setting that data was gathered. I witnessed this being done a number of times to decide who should be voted as class prefect as well as deciding how the classroom should be arranged for 'our day' celebrations. The children are used to this way of doing things and are familiar with it. It was also less intimidating for them as I engaged their classmates to help with the counting and recording of counts, and I was thus able to seek information from them without disrupting their everyday routine of doing things. Moreover, information obtained in this way was further corroborated through focus group discussions and in-depth interviews with the children.

The information presented was obtained from a total of 105 children through class interactions and focus group discussions. 59 of them were girls representing 56.19, % and 46 were boys, representing 43.81%.

Table 4. Children’s health complaints within a one-month recall (from a total of 105 children)

Complaint	Girls	Boys	Total
Headache	45	38	83
Malaria	47	33	80
Stomach ache	41	19	60
Body pains	42	12	54
Diarrhoea	31	20	51
Typhoid	38	9	47
Cough	18	11	29
Eye infection	17	9	26
Chicken pox	11	4	15
Total	290	155	445

Table 4 shows the common health complaints that the children have within a one-month recall. From the table it is clear that there are nine health complaints that are of concern to the children. It must be pointed out that the children named these illnesses as such. In asking further about how they knew that they were suffering from illnesses within a particular illness category, some pointed out that they were diagnosed in the hospital by a doctor for these illnesses, as illustrated by Fatimata, a ten-year-old girl:

When I told my mother that my head was aching, she said that I should lie down. In the evening it was still paining me and she gave me fried rice but I couldn’t eat it. In the night when I was sleeping I just wake and started screaming calling my mother, calling my mother. I couldn’t do anything. So my mother rush and come and touch me and my body was hot so in the morning we went to hospital and she took my folder and we went and saw the doctor and they made us do a test [for malaria and typhoid] and then we go home... The next day we went again and the doctor say that it is malaria so I have to stay in the hospital for some time.

Most of the children relied on symptoms from previous health experiences as well as symptoms they attached to particular disease categories to determine that they suffered from these ailments. Eleven-year-old Wumpini shared her experience thus:

My whole body was paining me and I was feeling cold and I couldn't eat anything because I'll vomit. My body was also hot and my hands and legs [touching her joints] were paining so I already know that it is malaria.

There were a total of 445 responses. The children recounted their experiences in multiple responses after they listed the health complaints. Gender wise, there is a higher total count for health complaints by girls (290) than boys (155). Two explanations could account for this. In the first place, the number of girls in some of the classrooms are slightly higher than boys. For instance, in one of the classes of 55 children, only 20 are boys. Secondly, from my experience during data collection more girls were interested in taking part in the data collection than boys. They were also more open than boys in disclosing their health experiences. Most of the boys were more receptive after I had spent a lot of time with them, towards the end of data collection.

Further, from the table it is obvious that headache and malaria rank high amongst both boys and girls. This could be due in part to the time of the year when this data was collected (between May and July). This is the beginning and peak of the rainy season in the northern part of Ghana and as a consequence of the rains there are lots of stagnant waters and blocked gutters which serve as breeding grounds for mosquitoes. Headache could also be high on the list because, as shown earlier, headache in combination with other bodily sensations like body pains and loss of appetite is often attributed to malaria. This could perhaps account for the high numbers presenting with headache, malaria and body pains. Again, teachers and parents refer to headache and stomach ache as two of the commonest health complaints that children present. When parents and teachers were asked what children complain most about it was typical to get responses like *'Ohhh...it is the usual headache, stomach ache and general body pains'*.

Eye infections were also mentioned, and although the number is not as high as typhoid and diarrhoea, it is worth mentioning that there was the annual outbreak of the eye infection commonly known as 'apollo' during the data collection, and so many of the children in both schools contracted it at the time. This may be the reason why it is part of the list of common health complaints. As a result of

my close interaction with the children, I also suffered from it at the time since it is highly contagious.

In spite of the range of reasons that may account for the health complaints that the children presented, it is noteworthy that they are similar – especially malaria, diarrhoea and typhoid – to the common illness experiences of other primary school children who have been studied on the African continent: Uganda (Akello, 2010; Wasike, 2007), Tanzania and Zimbabwe (van Reeuwijk, 2001; Barnys, et al. 2015), Kenya (Geissler et al., 2000; Geissler et al., 2001; Onyango-Ouma et al., 2004), and Benin (van Reeuwijk, 2001).

5.5 Dealing with not feeling well

Once children identify that they do not feel well and build a ‘diagnosis’, they make use of a myriad of ways to deal with the situation. When children were asked how they deal with not feeling well, they said that they make a complaint to the adults they interact with (teachers, parents and other family members), they talk to their peers for consolation or, as ten-year-old Najat put it, *‘I just manage it myself.’* By ‘managing’ it, children refer to either keeping it to themselves, doing nothing about it or self-medicating in order to feel well. In this section, I focus primarily on what children themselves do without the intervention of adults – in their words, how they ‘manage’ it. The other ways of dealing with not feeling well will be dealt with in the subsequent chapters.

5.5.1 ‘I just manage it’: Self medicating and treating each other

The idea of children dealing with their health complaints by themselves resonates with the Ghanaian context of medical pluralism where people manage their illness by themselves either through the use of pharmaceuticals or herbal remedies (Twumasi, 2005). The largely unregulated pharmaceutical market in the country make medicines readily available to those who want to use them. Senah (1997) observes that in Ghana all types of pharmaceuticals can be bought without prior consultation with a professional or without a prescription. What this means is that it is the individual’s ability to afford the drug that matters. For

children, it can be argued that this situation gives them some form of leeway in dealing with their health complaints. This is because they can easily walk into a pharmacy or drug store and buy medicines without prescriptions. Eleven-year-old Adisa shares her experience:

...I took money from my bag and went and bought medicine. I told the pharmacists I have headache and they gave me para [paracetamol] and some small medicine, I don't know the name and I took it.

Children who have the money are able to buy medicines to treat whatever ailment they believe is bothering them. This means that the ability to opt for a particular way of dealing with feeling unwell is afforded by the types of resources available to the child. The children display knowledge of various medicines, both western and indigenous, and their uses. These medicines largely include antimalarials, painkillers and antibiotics.

They also know the different brands that exist for these medicines. For instance, in referring to painkillers, the children usually mentioned the different brands on the market including *Efpac*, *APC*, *Gebedol*, *Tramadol*, *Quick Action* and *Teeda*. Although I did not intentionally set out to look out for children's encounters with pharmacists and drug store managers, I could not help but observe in some shops where children walked in and requested to buy antimalarial medicine and antibiotics. In these encounters, the children just mentioned the name of the drug and the person selling them tells them how much it costs. They pay for it and receive the medicine. Often the dosage is written on the package of the medicine by the pharmacist without then asking who or even the age of the person the medicine is to be administered to. In our interactions, the children tell me some of the brands of medicines are more potent than others based on their personal experiences with it or through recommendations from their friends. In one class interaction, for example, most of the children were of the view that 'Akumaa' APC (a brand of paracetamol which is heart-shaped—hence the name *Akumaa* which is a Twi word for heart) and *Quick Action* were more effective in numbing pain than another brand, *EFPAC*. However, it is worth noting that *EFPAC* comes in variants for adults and children and so there is *EFPAC Junior*

for children. Most of the children did not know this and were surprised when I mentioned the varieties. It is written on the pack of the medicine. The one most of them are familiar with is not suitable for children below the age of sixteen, yet most of the children were between nine and eleven years old.

Besides taking medicines by themselves, children also administer medicines to their friends. Some of the children complain about not feeling well to their friends as indicated earlier. When this happens, they may go to the pharmacy or drug store and buy medicines which they administer to their peers. Others bring medicines to school and 'help' their friends when the need arises. Eleven-year-old Fatima illustrates this:

Anytime I sit down, I feel like vomiting so my father bought me some medicine... they call it aspirin. He then mix it with water and give it to me to drink. I always bring some to school and some of my friends sometimes when they are sitting down, they always feel like vomiting, so I always mix it for them to drink...because we are walking together, they always say it and then I'll mix it for them to drink.

Upon enquiries to a pharmacist, I found out that apart from being used for pain and fever, aspirin is used to relieve inflammation and also to prevent blood clots. I also found out that it is not supposed to be used by people with allergies, asthma and bleeding disorders. The children are obviously not privy to this kind of information.

In other instances, friends become the last resort when other avenues do not work. When children fail to convince adults that they are unwell, they turn to their friends who acknowledge that they are indeed not feeling well. In a focus group discussion, one girl explained:

I told my grandmother my stomach is paining but she did not mind me. When I came to school I also told teacher S and he said I should wait small and see [wait for a while]. It was still paining but he didn't give me medicine [Teacher S] so I told my friends and they consoled me. During second break, my friend Ama went and buy para and I took it and it stopped paining me.

Primary school children on the African continent self-medicating is not new (Akello et al 2007; Wasike, 2007; Geissler et al. 2000). Also among medicines used by children in these studies, painkillers such as paracetamol, antimalarials and in some instances antibiotics have been identified as commonly used. The similar context of these studies (Uganda and Kenya) to Ghana, where pharmaceuticals are largely unregulated, may account for this trend. However, I argue in subsequent chapters that it is because children mainly conceptualize their illness sensations as biomedical in nature that they greatly rely on medicines as a remedy. The larger picture of young children self-medicating with painkillers, antimalarials and antibiotics pose a public health concern given recent concerns about increasing drug resistance to certain disease.

In addition it is reasonable to assume from the analysis that the children's strategies for dealing with feeling unwell can be related to adults' health-seeking behaviour. Children similarly rely on the following variables before taking action for their illness: a) recognition of and significance attached to the symptoms, b) perceived seriousness of the illness, c) the persistence of the illness, d) the perceived cause, e) knowledge of illness remedies, and f) faith in the efficacy of the medicine available (Fiereman and Jansen, 1992; Mechanic, 1992; Asenso-Okyere et al., 1994; Tipping and Segall, 1995). It has been illustrated that as part of people's health-seeking choices they make use of the professional sector, which is synonymous with biomedicine (Kleinman, 1980; Hampshire et al., 2011). No child in this study had taken the decision to go to or actually make use of a health facility by himself or herself except in the company of an adult. In this way, health seeking may be a more complex process that constitutes several decision-making processes and choices than is often illustrated (Mechanic, 1992; Asenso-Otchere et al., 1994; Tipping and Segall, 1995; Senah, 1997). Of these processes and choices, the specific context of social actors matter. I suggest therefore that the specific context of the children, which allows for people's heavy reliance on pharmaceuticals for their ailments, is reflected in the children's health-seeking behaviour.

5.6 Learning to feel unwell: Children's source of knowledge in their ill health experiences

The discussion so far highlights that children do not act in a vacuum. They are not an isolated part of the society, but rather they interact with and are greatly influenced by happenings within the larger society. They are thus actors in relation to the existing social structure, which either enables or constrains the extent to which they have the capacity to act (Prout, 2005). Thus children learn how to be unwell. As pointed out earlier, children make use of socially sanctioned cues for feeling unwell. They do not just know these cues but the necessity of identifying and making use of them. Over time they have learned them through socialization processes but more importantly in the mundane interactions that go on either face to face or through other media.

Blubond-Langner (1978) has shown through her study of children with leukaemia that children have several sources of knowing about their illness. The children read clues off pharmaceuticals, and take note of the types of treatments they undergo at every stage of the illness and adult's behaviour towards them to make sense of their illness. However, in this present study, where children have not encountered a health professional or institution, I highlight ways in which they know about their illness. In exhibiting knowledge about their bodies and how they feel, the children in this study rely on several sources including self-reflection, the media, the home, peers, as well as lessons taught in school.

5.6.1 Self-reflection

As already illustrated, children are aware of their bodies and how they function. When there is a problem with any part of their body, they are able to tell that all is not well with them. They rely on their bodily sensations over time and make use of past experiences with their bodies to frame and make sense of feeling unwell. In interacting with children they often make references to past bodily sensations to justify why they feel they are suffering from a particular ailment and not another. For instance, a ten-year-old girl asserts that:

...that is how I feel when I have malaria...so I knew that I was getting malaria again.

In this way, the physical body of the child as well as the child's understanding of self in order to depict what is normal and what is not is laid bare. Martin (2015) aids an understanding of the ways in which the child's body is both biologically and socially constructed. That is, on the one hand the body is biomedically defined in terms of the bodily sensations a child feels such as headache and high body temperature, and on the other hand, as Martin aptly puts it, this is socially rooted and co-constructed in shared beliefs and values. Thus, while the children draw on knowledge of medical diagnosis, through self-reflection they also rely on bodily sensations that were accepted in the past as a sign of a particular ailment. This then becomes their sort of 'truth' about the reason they feel a certain way in their body.

5.6.2 The media

In using the media here, I refer to television and radio. These are common sources of entertainment and information within Ghanaian society. The structural adjustment policies of the 1980s liberalised trade, leading to the commodification of pharmaceuticals. This situation, coupled with the largely unregulated markets for medicines in Ghana, mean there is competition by pharmaceutical companies to market their products (Senah, 2001 and 1997). These companies make use of the information channels that are available to the average citizen to promote themselves. In this way, advertisement of medicines on television and radio plays a huge role in children's knowledge of medicines and their uses. The children I interacted with often referred to brand names that have their adverts aired daily on TV and radio. For instance, the children talked about 'Quick Action', Efpac, Gebedol, Teeda, 'Nmofra Commando' and 'Akumaa APC', which are all brand or advertising names for paracetamol. They also referred to antimalarial medicines with brands names like Lofna 50, Mala 2 and Lonart. These medicines are regularly advertised on TV and radio.

Aside being a platform for knowing about various drugs and their uses, the media also serves as a source of health literacy campaigns. During an interview with an eleven-year-old girl in class five, she explains:

My mother and I were watching a movie and a girl took medicine. When she took the medicine she died. My mother told me, have you seen why I tell you not to take medicine when I am not there? It is like the girl in the movie is not yet even up to 20 years and she took 20 years old people medicine and because of that she died so me if my mother didn't ask me to take medicine, I will not take it.

5.6.3 The home

Langellier and Peterson (2004) highlight that meaning-making happens within families through ongoing communications during daily life. This serves as a vehicle for transmitting and reproducing particular ways of viewing the world. Children not only observe the ways in which parents and guardians do things in relation to health but also rely on what they say in forming their own impressions. For instance, an eleven-year-old girl had this to say about why she was unwell:

Anytime I am about to get my eerm...eerm period my stomach will be pulling. So I told my grandmother and she said it's because I eat a lot of toffees that is why. So I stopped eating toffees...it has not stopped but I think small small [with time] if I stop eating toffees for a long time then it will also stop.

The home forms one of the basic arenas where children learn and are taught about expected behaviour within the society. They also learn from the home the necessary cues to exhibit in order to take on the sick role and legitimize their bodily sensations. Most of the children attest that medicines are kept at home and are administered to them when they do not feel well by their parents or whoever they live with. They observe the ways in which these medicines are administered, and at times when they are home alone and do not feel well they take medicines to alleviate their pain. During a focus group discussion, for instance, an argument arose as to the right dosage for taking a particular painkiller (Gebedol). While some of the children felt that one tablet was enough one girl insisted that the right dosage is two tablets—her reason being that her mother gives her two tablets whenever she has a headache. The others did not agree and shook their heads disapprovingly while exclaiming. It should be noted however that the drug comes in either 50 mg or 100 mg packages and depending

on this, the dosage is decided. However, for the children what stood out is what their mother gave them when they needed to take the drug.

5.6.4 Peers

As indicated earlier, one of the pioneering works on the illness experience of children highlights the role of peers as a source of knowledge for terminally ill children to become aware of their world and to make sense of it (Bluebond-Langner 1978; 1991). Although focused on terminally ill children with a diagnosis of their ailment, it proves useful to gain insights into the roles peers play in the illness experiences of children. Children do not only assist their peers in seeking a cure for health complaints but also play a role in framing and describing what they feel. The children bring their past experiences to bear when interacting with each other and so based on past episodes of feeling unwell they help their peers make sense of what they are feeling when they present similar signs. 10-year-old Emmanuel illustrates how he knew he had typhoid as follows:

Alhassan told me that I have typhoid. He said that when he also have typhoid it will be like malaria and then he will be going to toilet too...like my body was hot, and my head was also paining me and my stomach too. I lose appetite too and I was just feeling weak in my body.

From the above it is clear that a diagnosis is given based on the past experience of a friend. For the children, it does not matter whether this diagnosis aptly tells what is wrong with them. Its authenticity lies in the fact that it comes from a friend with whom they are close and who can verify the claim of a particular illness from their experience in the past.

5.6.5 Lessons taught in science class

It has been put forward that besides the home, schools form key structuring institutions of children's social lives (Mayall, 1998). Children do not only meet and learn from their peers, but they also engage in the acquisition of knowledge through the lessons that they are taught in the classroom. The children pointed out reasons why they felt they were suffering from particular illnesses such as malaria or typhoid because '*teacher taught us in class.*' They are able to

give a name to a collection of bodily sensations because they represent symptoms attributed to tropical diseases that they are taught about in class. The children are able to follow some form of disease etiology to classify their symptoms and to self-diagnose. For instance a child may conclude that what they are experiencing is malaria if the time of the year is the breeding period of mosquitoes and they have been exposed to them. The environment they live in and what they learn about this environment serve as sources of knowledge in dealing with their illness experiences.

5.7 Conclusion

To sum up, this chapter has sought to illustrate how children construct their sensations of illness, how they make sense of these feelings and what they do to relieve these. It emerges that children rely on non-specific feelings such as '*feeling some way*', particular feelings such as '*pain in the body*', specific feelings in a specific part of the body like '*headache*', visible signs such as '*hot body temperature*' and then a named disease category like '*malaria*' as ways of building up a diagnosis and making sense of their bodily sensations (Campbell, 1975). It is also clear and worthy of note from the analysis that the children largely frame their sensations of feeling unwell in biomedical terms. This aspect of making sense of their illness will be dealt with in depth in subsequent chapters.

In these processes the children are not passive recipients of cures but rather active in framing and naming what they are feeling. Right from a vague complaint, children explore their bodies based on their own subjective experiences of their bodies, and employ knowledge acquired in the past. They also engage in this process collectively with their peers, and refer back to experiences dealing with similar circumstances in the past. Children are constantly engaged with the interactions that are happening in the context of the school, family or community in which they find themselves. These environments become fundamental influences for them in making sense of their social world in relation to their illness experiences.

This chapter has also highlighted the ways in which children engage in health-seeking behaviour once they establish that they are unwell. These patterns do not differ from the ways in which adults in the Ghanaian context engage in health-seeking behaviour. For instance the critical role of pharmaceuticals in health-care seeking in the country ultimately reflects in children's self-diagnosis and reliance on medicines to deal with not feeling well. It can then be argued that the specific context of the Ghanaian society not only influences the choices available to children to deal with illness but also shapes what children come to know about their bodies and the interpretations they give to different bodily sensations, given the kinds of illness categories they have been exposed to. It is however not adequate to rely on just the actions of the child within the larger social structure to understand their health experiences. It is necessary to delve into and to highlight the nature of the relations and relationships that exist between children and adults through the mundane interactions in dealing with ill health. This enables an understanding of how these relations either constrain or act as resources to enable children to take charge of not feeling well. And it is this that is looked at in the next chapter.

6

Children's social position and resources to deal with feeling unwell

6.1 Introduction

Children have been shown in the previous chapter to play an active role in making sense of and dealing with their sensations of feeling unwell. While the focus has specifically been on children's own perspectives in their illness experiences, this chapter draws on children's interactions and relations with adults in dealing with feeling unwell. This is to emphasise the view that children do not act in a vacuum, but relations with others in their society shape the nature and extent of their lived experiences. Thus, the second research question of this study—how does a child's social position influence the construction of and the strategies to deal with sensations of feeling unwell?—is addressed.

Using data gathered through observations of the daily happenings at school, focus group discussions and class interactions with children and teachers, and in-depth interviews with children, this chapter examines the nature of intergenerational interactions between the children and the adults in their everyday lives. I highlight the ways in which children's social class and gender shape these interactions and relations, which in turn either enable or constrain children's competence in making sense of and dealing with feeling unwell. In addition, I present the resources that children largely have access to in dealing with their illness complaints. In doing this I emphasize that children do not merely turn to adults for help but intentionally rely on specific social connections through which they can achieve desired results.

6.2 The social space in which children live their everyday life

In order to show the differences in the material and social life of the children encountered in this study, in this section I mainly describe the social space in which the children live. I illustrate this with the example of Lily and Suraya. They are both ten year olds in class five. Lily attends Baobab Primary School (BPS) while Suraya is a pupil of Shea Nut Primary School (SNPS). It is essential to point out that they only typify the life and routines of most of the children in both schools. There are some instances where children have similar routines

in both schools. However, the cases of Lily and Suraya depict a broader picture of the kind of children found in both schools.

6.2.1 Lily

Lily is a ten-year-old girl in class five at the Baobab Primary School (BPS). She lives in a gated house in a middle class neighbourhood in Tamale with her mother, father and younger brother who is also a pupil of BPS. Her father is the executive director of a government agency in the northern region of Ghana and her mother is a medical officer in one of the hospitals in Tamale. Lily's day typically starts at 6 am when she wakes up. She takes her bath and her mother prepares breakfast. Most often she has a chocolate beverage with bread and eggs or oat porridge. Other times she buys millet porridge tied in a plastic bag on her way to school. Her mother takes her and her younger brother in a car to school almost every morning. Sometimes, when her father is around, which is rare, he takes them in his car to school. Lily's mother often packs lunch for them, which could be rice and stew with boiled egg or fried meat, jollof rice with boiled egg or fried meat, indomie (noodles) with fried eggs or fried plantain with bean stew. Other days her mother gives Lily and her brother money ranging between 5 Ghana cedi (1 euro) and 10 Ghana cedi (2 euros) each, depending on whether they had breakfast or not. When Lily gets to school she joins the rest of the school for morning assembly and then marches to her class. Sometimes she arrives when the morning assembly is in session and so hurries to join the assembly. During the first break she shares her food or money with her friends and her friends also share theirs with her. At the close of day, usually at 4 pm, her mother picks them up. When their mother is not available, she contracts a taxi driver to pick them up. On Mondays, Wednesdays and Fridays Lily gets extra tuition in French, mathematics and science at home.

Interactions with the children and observations suggest that most of the children at BPS come from middle class family backgrounds. Many of the children live in gated houses (walled compounds with a gate that restricts entrance), houses built by their parents, rented apartments where facilities such as toilets and bathhouses are not shared, or government-owned bungalows. The majority of the children arrive in school in the morning in cars driven by their parents or a driver with a few being brought on motorcycles. Others are given money to take

a taxi to and from school depending on the schedule of their parents. Some parents also contract specific taxi drivers to take the children to and from school.

Those children who live within the vicinity of the school usually walk to school and back home. It is speculated among many residents of Tamale that the area has one of the highest rent rates in Tamale. To verify this, I checked with a couple of houses that were up for rent in the area. For a two-bedroom house with a living room, kitchen, bathroom and toilet, the rent quote per month was between 200 Ghanaian cedi (45 euros) and 500 Ghanaian cedi per month (about 100 euros) compared with similar housing facilities at 120 Ghanaian cedi per month (24 euros) in other areas in Tamale. That is about two to four times higher than in many other neighbourhoods. Usually these rents come with one to two years advanced payment contracts. Thus, unless one owns their own home, one will have to be able to afford a high rent to live in that vicinity.

The occupation of parents of the children I interacted with at BPS include lawyers, medical doctors, university lecturers, directors of government agencies, education directors, building contractors and engineers, business people (who mainly travel to Dubai and China to buy merchandise to sell in Ghana), traders (owners of popular wholesale and retail shops in Tamale), nurses, teachers and pharmacists. At least one parent has one of the listed occupations. There were instances where the mother is a stay-at-home mum, often referred to as a 'housewife'. However, in such circumstances, the father fell within one of the above-mentioned occupations. The children largely live with their father and mother. Other living arrangements include living with their father and stepmother, or with parents and other extended family members, or with grandparents. Some of the children are Muslim and are raised in polygamous homes. They either live with only their mother or with their father and stepmother. Most of the time, where they live is determined by its proximity to the school.

The children, especially those in the lower primary level (classes one to three), come to school with packed lunch and often a snack too. It is not uncommon during the break time to see the children eating a variety of meals from food flasks and bowls. Common among the foods the children eat are rice and stew

with an egg or meat and 'Indomie' (noodles) with fried egg. They usually wash this down with a pack of fruit juice or soda. Some of the children especially from class four up to the junior high school bring what is popularly called 'pocket money' in Ghanaian parlance. This is money that caters for their lunch and snacks. Food is sold on the school compound as well as sweets, fruit drinks and soda.

6.2.2 Suraya

Suraya is a ten-year-old girl who lives in a compound house. She is the third child of her mother and the seventh child of her father because her father has two wives. Her mother sells fresh vegetables at the community market near where they live. Her father is a craftsman and works as and when people need his services. Suraya typically wakes up at 5 am in the morning. On days when it is the turn of her household to sweep the compound she does it and takes the rubbish to the refuse dump close to her house. Then she takes her bath and prepares for school. Her mother gives her between 2 and 3 Ghanaian cedi for her breakfast and lunch. By 6.30 am, she sets off on foot to school with one of her classmates who lives close by. On their way to school they buy millet porridge tied in plastic bags with kooshe [bean cake] or kulikuli [peanut butter cake]. They suck the hot porridge from the plastic bag as they walk to school. When they arrive at school they go to clean the part of the school compound allocated to them and then join the other girls from their class to sweep the classroom. After this they join their schoolmates for morning assembly and march into their classroom. On days when she fails to make it to school on time, she receives beatings from the teacher on duty. During the first break, Suraya and her friends go to buy food from the food market in the school premises. They usually buy rice and beans with stew, Kenkey [corn dumpling], or boiled beans with Gari [grated cassava] mixed with palm oil. At the close of day at 1.45 pm Suraya and her classmate, together with other children who live in her neighbourhood, walk home together. She sometimes passes by the community market to help her mother sell her vegetables or she goes home and spends the time playing with her siblings and other neighbourhood children.

Interactions with the children at Shea Nut Primary School reveal that most of them can, like Suraya, be classified as children of working class and lower income families. The occupation of parents of these children include teachers, cleaners, low-grade civil servants such as clerks and messengers, artisans, petty traders, housewives (stay-at-home mothers) and farmers. Some of the children do not know exactly what their parents, especially their fathers, do for a living. The majority of them live in the compound housing system also described by Afram (2009) as 'Ghana's traditional house.' It is a popular housing type for low-income groups, usually made up of small rooms housing several households with an open courtyard and shared facilities such as toilets, kitchen and bathrooms (Owusu and Otchere, 2013). Others with Muslim backgrounds often live in polygamous homes with their father, any number of wives that he has and their siblings. It becomes a large family compound with shared facilities. The wives take turns to cook or are solely responsible for feeding their children. It is a common sight in Tamale to find groups of men playing cards under the shades of trees while the women engage in petty trading to cook for the family. The children then carry the father's share of the food to him while he is seated with the other men.

The majority of the children walk to school every morning and back home at the close of day. A few are brought to school by their parents on a motorcycle. Others are given money to take a tricycle popularly called '*yellow yellow*' because of its yellow colour, which is cheaper than a taxi. Most of the time, the children are given '*pocket money*' for their breakfast and lunch. This ranges between 50 pesewas to three Ghanaian cedi, which is less than a euro. Some buy tea, millet porridge, rice water or wheat porridge tied in plastic bags for breakfast. They create a hole at the tip of the plastic bag and suck the food out of it. During break at school they have a variety of meals to choose from at the school market depending on how much money they have and are willing to spend.

From the two cases representing each school, it is reasonable to assume that the children in the two schools to a large extent belong to different social classes. Most of the children at BPS belong to families with middle class backgrounds while their counterparts at SNPS are more of a lower class background. In

categorizing the children as such, I mainly rely on the occupations of their parents and the lifestyle it affords them. This is because it has been indicated that education remains a crucial decisive factor of social differentiation in Ghana and so the middle class in Ghana is defined on the basis of occupation and education (Behrends and Lentz 2012; Budniok and Noll, 2018). Considering the children in this light, in what follows I illustrate ways in which their social class shape interaction patterns between them and their teachers.

6.3 Negotiations versus Directives: Everyday Interactions at School

Observations of relations between teachers and children in the two schools show different patterns of interactions. At BPS, conversations between teachers and the children in classroom settings often allowed for dialogue and negotiations:

Teacher: By 10.00 you should all stop work and bring your books for marking

Children: [chorus] ohhh Teacher M.

Boy 1: We cannot finish ooo. The work is plenty.

Boy 2: Sir we can add our break time. So that we finish

Children: [majority chorus] Yes yes

Teacher: You'll not have any time to go for break again ohh.

Girl: Yes we want

Teacher: Ok when you finish Naana can bring the books to the staff common room. (Field notes, 10th November 2016)

The above ensued when a teacher gave the children in class six a class test. When the class time was almost over, the teacher did not command the children to hand in their work. Rather, a kind of dialogue ensued between him and the class, and in the negotiation that followed, the children had their way. This scenario was quite common with the children and teachers. For instance when a certain media organization came to make videos of the children for a television show, the teacher asked that they use the '*summer hut*'. The children however felt that the '*summer hut*' was too open and so there would be interference from the younger children. After a couple of exchanges with the teacher they agreed

that they should have the shooting done in the classroom. I noticed that most of the time the teachers were in no hurry to force decisions on the children. They would often add 'or' to an instruction and this gave the children the opportunity to voice their opinion. Their tone was also not harsh and so sometimes the children did not really take them seriously. Even when threats were issued, the demeanour of the teacher did not put fear in the children. For instance at the morning assembly a teacher announced:

I am on duty this week. Those of you who like to eat and forget it is break over. When I catch you ehh you'll smell pepper [be in trouble]. [There is laughter from the children]. You are laughing eh. Ok continue laughing till I catch you...so when you hear the bell run to class okay?

At the end of the first break that day, there were still some children buying food from the vendors and others still walking about on the verandas. This is not to say the children disregarded instructions from the teachers, but they did not live in fear of them like at the SNPS and this was all about how the teachers engaged with them. Again, their experiences with them in the past reinforced their notion that the teachers only issued the warning but were not to be taken too seriously.

Further, the children were often talked to and not necessarily ordered. The teachers encouraged and appealed to the children to see reason and use this to influence their peers' behaviour. At one morning assembly, the head teacher told the pupils:

We have provided dustbins everywhere still you throw rubbish anyhow. Please respect yourselves and act like the ladies and gentlemen that you are. Be each other's keeper and have the school at heart. Caution each other to act right. When you see your friend throwing rubbish anywhere correct them.

In interpreting the head teacher's message to the children, I do not solely focus on the message, but also consider his demeanour and body language. That is, the message was delivered in a calm voice, he was audible but not shouting and he did not threaten by sticking out his index finger. Although there were

some teachers who did not engage the children in this way, the general pattern of interactions with the children was one of negotiation, dialogue and appeal.

In addition, the children did not live in fear of the teachers. As stated in earlier chapters, the children could go in and out of the staff common room whether there were teachers there or not. They did not run when they saw teachers approaching unless it was the end of the break period and they were still outside buying food or playing in front of the classrooms. A teacher's presence did not stop them from most activities they were engaged in. For instance, on the last day of the term, referred to as '*Our Day*', the children take part in various activities as a form of entertainment. They sing, rap, dance and mimic various music artists as part of the celebrations. During these activities, the children do not hold back even in the presence of their teachers:

Two girls mount the stage after they sent their phones to the music and dance teacher to connect to the loudspeakers. The song starts and it is a song from a popular female artist considered in Ghanaian parlance a 'bad girl' because of the sexual connotations and 'indecent' dress that accompanies her performances. The title of the song is 'date ur fada' with the opening lines of '...if you break my heart I go date your father.' The girls seem to have mastered the dance moves so they are quite similar to what is displayed in the song's music video. As they dance I become a little apprehensive and look around to watch the reaction of the teachers. Everyone seems to have a normal facial expression. There is no sign of judgement or reprimand, or even if they feel that way, they have done a good job hiding it and so I relax and enjoy the show. (Field notes, 14th December 2017).

What I observed was that the children were kind of being themselves. They most often did not act in one way in the presence of the teacher and another in his or her absence. The nature of the interactions translated into a calm, easy going and serene school atmosphere.

I offer two possible explanations for this pattern of interactions. In the first place, in a country like Ghana where social class and titles matter, the occupations of parents of this school may be a source of influence as indicated earlier. That

is, parents' occupations, which are rated higher than those of the teachers, may serve as a kind of power position on the part of parents over teachers. The second reason, which relates to the first, is the greater say that the Parent Teacher Association (PTA) has on how the children should be treated, which may give parents greater capability to exert some influence over the school and the kinds of relations and interactions it fosters. In other words, the pattern of interrelations between teachers and children may be due to the 'powerful' parents of the children. In this regard, I argue that power relations between adults are transferred to the children of those adults. That is, ways in which children are interacted with reflects the ways their parents are regarded.

In contrast, the teacher-child relations observed at SNPS can largely be described as strictly hierarchical. Teachers instruct children and the children obey. For instance during a class test situation the following ensued between a teacher and the class:

Teacher: Be getting ready to stop work

Children: Eiiishhh

Teacher: Whether you finish or not I am collecting the books. Instead of you to shut up and work you are saying eeeish.

[The children are silent]

[5 mins later:]

Teacher: Stop work!! If I find you writing I'll cane you. Hey you [pointing to a boy at the back] stand up. I said stop writing now! [Walks up to him and canes him even though he is already standing] Pass your books forward. [He packs all the books and calls a girl in front to carry the books and they both walk out. As soon as he steps out the quiet class becomes noisy. Then he peeps into the class and the children begin running to their seats and there is calm until his head disappears from the entrance]. (Field notes: 20th June 2016).

Most of the time the children were shouted at, ordered or threatened by the teachers. For example, a teacher on duty at morning assembly said to the children:

When the bell goes for break over, I do not want to see anyone loitering about here. Is that clear? If I catch you I will cane you and you'll forget yourself [while swaying the long cane from left to right].

The children run to class when the bell rings to signal the end of the break period. They are also very quiet in class until the teacher steps out. Their behaviour in the presence of the teacher often did not match their behaviour in the teacher's absence. Thus, compared with children in BPS, the children were not being themselves in the presence of their teacher. It appears that when the teachers are around the children exhibit behaviour they know is expected of them by the teachers. The children were often sanctioned when their actions were considered disrespectful:

A class five pupil is now arriving in school. When I asked her why she was now coming she tells me that she didn't wake up early this morning. Can you imagine? So I [head teacher] should come and sweep for her or what? So I have sent her back home to go and continue sleeping... Another boy also disrespected a teacher and has decided not to come to school today...he has sacked himself like that. (Headmaster to class five pupils, 20th June 2017).

This made the school atmosphere often quiet and tense. It was also very common to find children kneeling on the bare ground as a form of punishment. This corroborates Twum-Danso's (2010) assertion that the expected behaviour of children in the relations between children and adults in Ghana is reinforced through all forms of disciplinary action including physical punishment to maintain social order.

Similar to the explanations suggested for the relational patterns in BPS, it is possible that the nature of the occupations of the majority of the children's parents did not put them in a higher power position compared with the teachers.

In fact, in relation to some of the parents' occupations, the teachers hold the position of power. In addition, the school is controlled more by government directives than by the PTA. The result, as argued above, is that teachers in this school relate with the children in ways that they regard their parents.

Following the differences in the social and material world outlined, it is apparent that children of the two schools are exposed to different lived experiences in the mundane happenings of their life. In other words, their social class affords them different experiences in their everyday life. In this way, I relate these experiences to how it either enables or constrains children's ability to influence decision-making in dealing with feeling unwell.

6.4 The influence of social class on how children's competence in dealing with feeling unwell is constituted in child-adult interactions

I draw on some aspects of Lareau's (2011; 2002) concepts of concerted cultivation and accomplishments of natural growth to illustrate the bearing social class may have on children's competence in feeling unwell. These concepts were conceived to shed light on child-rearing practices between middle class and working class families in America. Concerted cultivation describes middle class child-rearing styles: parents engage children in multiple activities that keep them occupied throughout the day; children engage in contestation of adult statements resulting in extensive negotiations; there are weak extended family ties resulting in children often in homogenous age groupings; and all this results in the child learning an emerging sense of entitlement (2002: 753). Accomplishment of natural growth on the other hand depicts child-rearing practices by poor and working class families: parents allow the child to grow and 'hang out' particularly with kin; it is rare for a child to question or challenge adults, leading to a general acceptance of directives; there are strong extended family ties resulting in children often in heterogeneous age groupings; and all this leads to an emerging sense of constraint on the part of the child (2002: 753).

Although these concepts are used to illustrate family life and child rearing in a western society and its brief description here may seem rather trite, its fundamental tenets help to make sense of the ways in which social class influence child-adult interactions in dealing with children feeling unwell. It also draws attention to how similar relational patterns are exhibited among middle class and lower class families even in the context of a non-western society.

From the descriptions of the daily life of middle class children in the earlier section, it is apparent that the children's lives are organized to keep them occupied, with the extension of the school day after the official closing time, and extra tuition in specific subject areas such as French and mathematics. Their routine is usually from home to school and back in that order. The children of SNPS, on the other hand, follow the official time for primary schools and so they have the rest of the day to themselves. Ten-year-old Amina explained:

In the afternoon when I close from school sometimes I go and play with the children in our house [compound house] or my mother will send me to go and buy small small things [ingredients] and she will cook...even when my brother is sick she can also send me to go and buy medicine...like fruit medicine [multivitamins] and Gebedol [painkiller]. Then I can also help her [assisting with chores] in the house.

In this way they get to take part in household chores and run errands, including buying medicines from pharmacies. These activities imbibe in them the ability to walk into pharmacies and chemists, as illustrated in the previous chapter, to buy medicines to deal with not feeling well. Their time is not scheduled and this gives them freedom to engage with other children. The pupils at BPS do not necessarily have this time. What this translates into is the ability of the children at SNPS to interact extensively with other children and draw on their experiences and knowledge concerning illness. In my interactions with these children, they were more likely to resort to their friends because they hang out more with their peers. They walk to and from school together, they finish school earlier and so have time to play with their friends, and since they 'help' each other they return favours:

When we were going home and I tell my friend Fatiya that my head is paining and so she buy iced block [frozen sachet water] and I put it on my head. Small time [after a while] and then it stop. So another time when we are going home she didn't have money and she too her head is hot and I buy pure water [water in a sachet] and she pour it all over her head. (Ten-year-old Amina, SNPS).

In addition, the organization of the children's daily life influences teachers' strategies to deal with children's claim of illness:

I was vomiting and my body was hot so when I told our class teacher she ask me that can I go home and say that no. So she asks that who do I come to school with and I call my two friends and she say that they should take me home. (Ten-year-old Fatawu, SNPS).

A teacher at SNPS corroborates the child's story:

We normally ask them [the children] to go home. If they cannot go by themselves we let some of the children to take them to the house. We are not doctors or nurses to be giving medicines. (Matthew, male teacher SNPS).

Thus it seems teachers believe in the ability of the children to initiate steps (e.g. go home) to deal with their illness. In the case of BPS, however, most teachers resort to calling parents to pick up the child and so rely on parents to initiate the process of health seeking:

One other thing we usually do is to call the parents so that they can pick the child home. So that if they [parents] wants they can take them to hospital or anything that they want to do. (Teacher S, BPS).

Another dimension of Lareau's categorization is that children engage in contestations and negotiations of adult statements in middle class families versus general acceptance of directives by children in lower classes. In this regard, my observations of interactions in the two schools concur with this: middle class children in this study engage in negotiations and dialogue with

teachers, while the lower class children respond to directives. These patterns reflect how children report and make a case for feeling unwell:

I went to Teacher S and I told him that I am sick. So he asked that what is wrong with me and I tell him my head is paining. So he touch my head and my neck and say that my body is not hot so I should go and lie on the table that it will stop...I go and tell him again and he say that did I sleep early and I said that yes and he said then what is wrong and he say that should he call my mother and I say that my mother has travelled so I will go and lie down in the library. (Ten-year-old Ursala, BPS).

Eleven-year-old Khadija at BPS also indicates that:

When you tell Madam [female teacher] that you are sick she will ask you whether she should call your mother or whether you can wait till closing time. The one that you'll choose then she will do it for you.

These approaches allow children to persist in their claims of illness as well as to take part in making a decision about how to deal with it. For children in SNPS the opposite happens:

I told my teacher that my stomach is paining and she just shout that is it not now now now [not too long ago] that I am eating beans and now my stomach is paining? She say that I should go and sit down and the class is laughing at me. (Ten-year-old Zuleiha, SNPS).

It is obvious that the children in this school often do not have the chance to persist in their claims given the nature of interactions that exist between them and their teachers. Thus their competence in this sense is not regarded by adults. While it appears that the children of SNPS are constrained by the nature of their interactions, it is possible that this actually pushes them to self-diagnose and to self-medicate. This is because it was observed that most of these children were likely to medicate themselves once a disease category is resorted to as

indicated in chapter five. It is arguable then that inherent in a possible constraint on a child's competence is room for innovation on the part of the child.

Again, the nature of social connections for the children differs. Lareau (2011) refers to this as weak extended family ties for middle class children and strong extended family ties for lower class children. The illustration of the social lives of the children shows that most middle class children live in more nuclear family style homes, with privacy, than their lower class counterparts. They are thus restricted in who they report feeling unwell to. Most of the children I interacted with at SNPS, on the other hand, indicate their access to more family members and other adults in their circles from whom they can seek help when they do not feel well:

My uncle, he completed UDS [University for Development Studies] always pick me on his motorbike to Kareem [Quran recitation school]. Sometimes we go to the mosque by our house and pray there. When I am sick I will tell him and when he has money he will buy me medicine. (11-year-old Mustapha, SNPS).

Ten-year-old Linda at SNPS also indicates that:

My grandmother is staying in the next house by our house. If my mother is not there I will go to her house and tell her. Sometimes if she has medicine in her house she will give me. Sometimes too she will let me or some girls staying with her to go and buy it [medicine].

For these children, these extended families seem less strict than their parents and teachers. It appears that these family members do not question the children's competence like their teachers or parents would and so allow the children to exert influence in their claims. They are thus considered easy to deal with by the children when making claims of feeling unwell:

As for my grandmother if you tell her that you are sick and she has medicine she will give you and she will let you lie down and not do anything (take part in

household chores) but my mother will say that you are telling lies (Ten year old Linda, SNPS).

Further, Lareau (2011) asserts that the consequences of these patterns of child-rearing practices is the sense of entitlement among middle class children and a sense of constraint on the part of lower class children. With regard to the sense of entitlement, I suggest that the children encountered in this study only manifest their lived experiences in their everyday life. That is, the organization of their life and the interactions it affords is by virtue of the social class they belong to and not necessarily a privilege for one group of children over the other. In addition, taking into account the analysis so far, I argue that both of these patterns of social life and relations work to either enable or restrain the children whether within the middle classes or lower classes.

Further, unlike Lareau's dichotomy, I suggest that both middle and lower class children experience a sense of powerlessness and constraint. While the organization of social life restricts the freedom of middle class children and so constrains the extent to which they can actively deal with their illness, the nature of interactions which is more directive in style also constrains lower class children's competence in their illness experiences. Inherent in these constraints, however, are opportunities for children to be innovative in dealing with illness. Lower class children for instance are more likely to rely on self-diagnosis and self-medication. They also depend on adults who do not question their subjective experiences of their body. The social class of children thus proves useful in understanding the nature and depth of relations between children and adults. Specific to this study it shows how these interrelations play out in everyday experiences like illness. Besides social class, gender also emerges as influencing ways in which children's complaints of feeling unwell are perceived and dealt with. In the section that follows, I detail this.

6.5 'Girls are more fragile than boys': the influence of gender on how children's competence in their illness experience is constituted

I begin this section with an extract from an observation of classroom activities in one of the schools. It was the first situation to draw my attention to ways in which boys and girls were conceived in the two schools:

During a class test some of the children [only girls] begin to submit their books. The teacher in the classroom points out that so far only girls have completed the test in time. He adds that the boys are a disappointment to him by not finishing in time and should sit up. Later he remarks that if the girls perform better than the boys, the boys will be shamed. When the first boy to finish his test moves forward to submit his book at the teacher's table, the trainee teacher makes the class clap for him. (Field notes, 20th June 2016).

This observation clearly captures the different expectations of being a boy or girl observed in the context of the school. Boys appear to be expected to excel within the confines of the school more than girls. Interactions with parents also reveal the emphasis on girls rather than boys to do household chores as part of their social obligations:

They [girls] must learn to do the things [chores] around the house. They have to learn to cook as they will carry this with them forever. So for me from day one I make an effort to include my daughter in everything [household chores]. (Agnes, mother of four).

This trend however reflects a general pattern within the society. It has implications for the ways in which the illness experiences of boys and girls are viewed and dealt with. In my initial encounter with the teachers, they often made suggestions to me to focus more on the girls than the boys because girls complain of feeling unwell more than boys. Boys as young as six were often told to be 'tough' and not 'cry' like girls in situations related to pain in the body:

A boy was brought by his class teacher to the teacher who keeps the first aid box. He had fallen in a wet classroom and grazed his knee, and it was bleeding. The teacher picked out a pair of scissors and held a piece of gauze with it. He first poured water on the graze and the boy screamed, bringing some of the children from their classrooms to watch. The teacher told him to be a man, to not cry and be tough. He then applied methylated spirit and gentian violet. By this time the little boy was uncontrollable. Just as he finished dressing the wound another girl was brought from the same class with a graze on her elbow and knee. The same procedure was applied but the girl did not utter a word. The teacher praised her and questioned who the real man is. (Field notes, 13th December 2017).

Thus the boy's subjective reaction to his own body was not in consonance with the expectations that the teachers have of boys. In the same vein, the girl reacted in contrast to what was expected. This was in a situation where the children did not need to form or find words to describe their bodily sensation because the graze with blood oozing out was visible and obvious to everyone. In circumstances where it was the subjective experience of the children these differences were often still relied on.

In the case of girls, teachers held an ambivalent position concerning their illness claims. On the one hand, girls' competence of their subjective bodily experiences was usually suspended. This is because the teachers view girls as often claiming to be ill and so not to be taken seriously:

When you take the girls for instance, the least thing teacher my head, or my stomach or I am sick. They seem to find enjoyment in just coming over to you to bother you with sickness. Almost every day a girl will come with one story [illness complaint] or the other. I tell them if you wake up and know you are sick then don't come to school. Stay in your house and be sick. (Florence, female teacher).

On the other hand, the girls were considered as '*fragile*', '*not very strong*' and '*easily falling sick*'. By perceiving girls this way teachers expected that they would complain of feeling unwell. Taking this position meant that their claims are not easily discredited:

You know girls are more fragile than boys. They easily fall sick. It happens all the time. Most of them when they come to me I consider all that when they come to tell me their sick. I give them the benefit of doubt. (Mohammed, male teacher).

Another teacher was of the opinion that:

Girls are not very strong. The least pain they will take notice of it. So for them it is normal that if they are sick they will tell you. (Marilyn, female teacher).

It will then seem to the teachers that the perceived physical vulnerability of girls serves as a validation of their competence in making sense of their bodily sensations. On the part of parents, girls' illness complaints are more likely to be interpreted as a ploy to escape household duties:

When they [girls] don't want to help around the house then sickness comes to the rescue. For me I know all the tricks so it won't work (Agnes, mother of four).

Children also indicated that when they complained about being unwell at home their mothers especially translated it as unwillingness to do household chores:

Most times when any of us [Marcy and her sisters] tell my mother that we are sick then she will say that it is not true [and] that we don't want to work. As for me I can wash bowls [do the dishes] so I don't care but I cannot cook because I will burn the food and my mother say that she does not like that so why will I now say that I am sick because I don't want to work? (Eleven-year-old Marcy).

Ten-year-old Linda also reports that:

As for my house when you [girls] say that your somewhere is paining my mother will just say that so it is because of the work [dirty laundry, dirty dishes or errands to be run] you have seen eh that you are telling stories. But it is not like that.

In this instance it is reasonable to assume that girls' claims of illness are not taken seriously because of the need for a social obligation to be met. Their

competence is thus suspended and they are perceived as being unable to differentiate between what is required of them as girls and genuine bodily troubles.

The perception of boys as tolerant of pain and being '*tough*' also played out in the reception of their illness complaints. In the first place boys, unlike girls, were not reported as regularly claiming to feel unwell. In this way, when a claim is made both parents and teachers take it seriously:

You will hardly find boys, especially the older ones, telling you they are sick, hardly. Sometimes you are the one who will spot that something is wrong but even then some will not admit most especially the older ones. So if he comes to tell you he is sick then it is really true. (Florence, female teacher)

A parent also acknowledges that:

My son will never tell me he is sick. It's not common. It's not as if he fears the medicine or anything. He just won't tell you. But his sister will run to me with the least thing and worry me until I listen to her. So if he tells me he is sick I take him seriously (Sumaya, mother of three).

In addition, while girls are considered not capable of enduring pain, boys are seen as not only being capable of enduring pain but that it is necessary to endure pain because they are boys, as illustrated in the field note excerpt above. When boys complain of feeling unwell then it is considered that the discomfort is beyond them and so it is truly what it is:

My boy is the quiet type. He hardly falls sick. Even towards the end of the school week when you see him looking tired and exhausted, he will never complain...so when he tells me that he is sick I believe him. (Agnes, mother of four).

It is arguable from the analysis that the perceptions teachers and parents hold about boys and girls influence the ways in which decisions are made about their ability to comprehend their bodily sensations. Wasike (2007) similarly

observed differences between boys and girls in their illness experiences. While he looked at this from the angle of how boys had more access to resources to deal with fever than girls, this study sheds light on the influence of gender on how children's competence in their illness situation is constituted. Focus is now turned to the resources that children intentionally rely on in their experiences of feeling unwell.

6.6 Resources children rely on to deal with feeling unwell

In discussing the resources children lean on to deal with feeling unwell, I draw on data that illustrates who children choose to report not feeling well to both at home and in school. This is because I captured children's resources within their social connections since the focus was on how social relations and interactions with adults influence their illness experiences. In addition, I underline the reasons that surround the children's decisions about relying on a particular individual or not.

In Table 5, I present who children report feeling unwell to at home. The table combines responses from children at both BPS and SNPS. I did not separate their responses because differences did not exist as such in terms of numbers about who the children decided to report to both at home and school. The only differences identified were in terms of the reasons for their decision to choose a particular person to report to. As will be illustrated, the differences in the reasons for their decisions are largely due to the interaction patterns already alluded to in previous sections of the chapter.

Table 5. Reporting not feeling well at home within a one-month recall (Total of 105 children)

Complain to	Girls	Boys	Total
Mother	48	23	71
Friend	36	17	53
No one	12	27	39
Sister	30	3	33
Grandmother	27	3	30
Aunt	21	5	26
Uncle	18	7	25
Brother	18	5	23
Father	7	13	20
Total	217	103	320

As indicated in the previous chapter, there were more girl respondents than boys. From the table, there is an indication of a total of 320 responses. Overall, both girls and boys mostly report not feeling well to their mothers. Also more girls—more than a quarter (126 responses) of them—report feeling unwell to their mother, sister, grandmother and aunt. In comparison, only 34 out of 103 responses from boys are to this group. Although both boys and girls indicate relying on a mother figure, this is especially true for girls. This pattern of responses has a number of reasons. In the first place, for both children at BPS and SNPS, most indicate that they spend more time with their mothers than their fathers, and note the intimate role of their mother in their day-to-day activities:

My mother brings me to school and comes to pick me again. So I always tell her if anything is wrong (Ten-year-old Anita, BPS).

Or in the case of Linda, a ten-year-old girl at SNPS:

My mother will wake me up in the morning and when I am going to school she always give me money to buy food on the way. So I will just tell her I’m sick.

Secondly, the children point out that their mothers are usually available or have more flexible work schedules and so they easily have access to them. Also their mothers are the ones who take them to the hospital when necessary:

My mother has a table in front of the house and we sell toffee, pure water [sachet water] and charcoal. So she is always in the house (Ten-year-old Adiza, SNPS).

Nana Ama, an eleven-year-old girl at BPS, also indicates that:

My mother eh mostly by 5'o clock she comes to the house but my father eh he travels a lot. Sometimes even when he is in the house and I am sick he will say that my mother should take me to hospital because he is busy...one time he said he will send me and my mother and he couldn't. The following day the same thing so he just told my mother to send me to the hospital because he is busy.

In addition, I observed in BPS that mothers were mostly the ones who did school runs for those children who had to be brought to school and picked up at the end of the day. It stands out that they seem to be more available or more involved in the everyday life of their children. This reiterates Mayall's (2015) assertion that mothers are much more involved in the health experiences of their children. It appears that they are as much involved in their illness experiences as well.

Besides mothers, the children's responses also indicate that they are more likely to tell their friends when they do not feel well. Some of the children rely on their friends when they fail to convince adults that they are feeling unwell:

My stomach was paining me and I couldn't do anything and then I told my grandmother and she didn't mind me. I went into the room and I lie down and small time [a while later] I told my grandmother again and she say that it will go [the pain will stop] So when I went out I was crying and I told my friends and they sympathize with me. Later on it was my period that was coming and I now know why my stomach is paining (Eleven-year-old Charlotte, BPS).

For some children at SNPS, they lean on their friends because they go together between home and school, they live in the same neighbourhood and play together:

We are three people that come to school. One of my friends, Fatiya her house is by my house and she is in my class. So when we are going home and any of us our somewhere is painig then we will tell each other or in the house if they have medicine she will give me some sometimes (Ten-year-old Amina, SNPS).

Most of the children who report to their grandmother, uncles, aunts and other family members either live in extended family households or live in proximity to these relatives. The convenience of having these family members around as well as the extent to which they are 'free' (friendly) determines who children report not feeling well to:

When my head was painig me and my eyes were turning me (headache and dizziness), my aunty was in the house so I tell her because my mother didn't yet come home. Me too and my aunty we are free [friendly] paaa [emphasis on being friendly]. (Eleven-year-old Zahra, SNPS).

Further, as indicated earlier, the children consider these family members less strict than their parents. I presume that the ease with which they are able to make a case of feeling unwell with them influences their decision to rely on them.

Within the school as well, children report not feeling well and seek help. Below I present a breakdown of who children in both schools often report to.

Table 6. Reporting not feeling well at school within a one-month recall (Total of 105 children)

Report to	Girls	Boys	Total
A teacher the child and parents are friendly with.	57	21	78
A teacher who has the parents' contact number.	54	20	74
A teacher who is caring.	54	13	67
A friend	38	22	60
No one	12	38	50
Class teacher	30	17	47
The teacher in charge of giving medicine	33	11	44
The health prefect	16	8	24
Any teacher	5	11	16
Total	299	161	460

The majority of the children (78) state that they report not feeling well to teachers with whom they and their parents are familiar with. Most of the children agree that a caring teacher and a teacher who has their parents' contact number overlap with a teacher whom they are friendly with. However, in some instances the children indicate that a teacher who has their parents' contact number may not necessarily be friendly with them. They only rely on these teachers because their parents have asked them to:

My mother said that anytime if anything is worrying me I should tell Teacher K because he can call her and let her know. (10-year-old Hafiz, BPS).

I observed in BPS that friendly relations are fostered and strengthened. Parents often stop by to talk to some teachers when they drop off or pick up their children from school. During religious festival celebrations such as Christmas, Easter, Eid ul Fitri and Eid ul Adha, parents send gifts to these teachers:

A girl from class six enters the room carrying a black polythene bag. She walks up to a teacher and hands it to him. He peeps into the bag and ask her whether it is beef or mutton. The girl replies that it is mutton. The teacher asks her to place the bag in the refrigerator. As she leaves he adds that she should thank her mother on his behalf for the 'salah' (Eid ul Fitr celebration) gift. (Field notes: 11th July 2016).

During '*our day*' celebrations as well, I observed that the children go round distributing gifts to some teachers. I particularly observed that one teacher most of the children reported going to when they do not feel well had his desk filled with so many provisions that it looked like a supermarket. Some of the children indicated that their parents send them with gifts while others persuaded their parents to buy them provisions to be given to certain teachers. It can be said that both the children and their parents intentionally nurture and foster relationships with teachers for the sake of the children. This practice also creates a certain kind of familiarity between the teachers and children. The children then draw on this when they do not feel well, knowing that they stand a greater chance of having their health complaints treated seriously:

I am free [friendly] with Teacher S. So anytime I am sick I always tell him. Then maybe he can call my mother or give me medicine or let me go and lie down in the library (Ten-year-old Maame, BPS).

As noted by Bourdieu (1986), social actors strategize in pursuit of desirable resources through social networks. There is thus a deliberate construction of social networks, which serve as a reliable source of other benefits (Portes, 1998).

The teachers on their part are aware that the children are more likely to report not feeling well to those with whom they are friendly:

When you are familiar with some of them they come to you. Maybe you taught them the previous year and they are still used to you. For instance one of my church members has her daughter here, she is in class 5. Often times when she has a problem she comes to me. (Matilda, female teacher).

Children of SNPS indicated that they relied on teachers who share the same ethnic background as them, attend the same church as them or know their parents on a personal level:

One of our Madam [teacher], she is from my hometown...so I like to go to her and tell her. (Ten-year-old Diku, SNPS)

In addition, some children, especially boys, indicate that they do not report to anyone, either at home or in school. This may be a reflection of the views of teachers and parents that boys do not often complain about feeling unwell. However, some of the boys stated that in their view they do not have to do anything to feel well again:

When my head is paining me like I'll not mind it then small time [after a while] it'll stop. (Ten-year-old Hardi).

6.7 Conclusion

The findings of the study presented in this chapter show that a child's social position, specifically social class and gender, play a role in either enabling or constraining their ability to influence decisions concerning their illness. Drawing on Lareau's typification of child-rearing practices between middle class and working class families in America, I illustrated ways in which the different lived experiences of middle and lower class children afford them different resources to deal with feeling unwell. In doing this I also highlighted the point at which these differences either enable or curtail a child's ability to influence decisions concerning their illness while arguing that inherent in an adult's disregard of a child's claim of illness is the opportunity for the child to innovate and manifest yet other forms of strategies to deal with feeling unwell. In addition I outlined the differences in how the competence of boys and girls in their illness situation is constituted in interactions with adults. While boys' claims of illness are largely taken at face value, girls have their subjective experiences of their own body suspended, especially when household chores are involved. This is as a result of the societal outlook on and expectations about boys and girls.

Further, I presented the resources, in the form of social connections that children rely on to deal with feeling unwell at home and school. It stands out that most often children intentionally choose these connections based on convenience, the ease with which they can make a claim of feeling unwell, similar ethnic background and familiarity. Both parents and children intentionally nurture and foster these relations for the sake of the children.

I now turn my attention to what constitutes adults' (mothers') reaction to children's claims of illness.

7

**Feeling the pain and seeing the pain:
Circumstances under which a child's claim
of illness is resisted, modified or accepted**

7.1 Introduction

In the previous chapter, it emerged from the data that when children choose to report feeling unwell, they are more likely to report to their mother, a mother figure such as a sister or aunt, or a teacher who exhibits qualities they believe mothers possess. The role of mothers in the children's illness experiences then cannot be overemphasized. In considering the circumstances under which the genuineness of a child's claim of feeling unwell is resisted, modified or accepted by parents and teachers, the views of mothers are largely presented. In addition, children's views about mothers as well as their narratives on their experiences with their mothers in the circumstances of their illness are resorted to.

To capture and enable an understanding of this interaction process, I begin the chapter by outlining the ideas children have about their mothers and how this influences the choice they make to report feeling unwell to them. Mothers' own views about themselves in relation to dealing with the illness of their children are also highlighted. Further, the ways in which teachers draw on their experiences as mothers to deal with children's illness complaints are discussed. I then synthesize the ideas of both mothers and children and detail how these play out or result in tensions and conflict in reacting to children's complaints about feeling unwell. Further, in viewing themselves as the custodians of their children's health and well-being, I illustrate how mothers' use their position to either resist, modify or accept their children's complaints of feeling unwell.

7.2 Children's ideas about mothers and how this influences their reliance on them when they feel unwell

In seeking to understand the role mothers play in the illness experiences of children, it is useful to gain an insight into how children view mothers and the understandings they have about who a mother is. This section of the chapter delves into the notions children have of a mother, precisely discussing how the context in which these children live reflects in the ways in which they see mothers.

During interactions with the children in this study, most of them referred to their mother or a mother figure (aunt, stepmother, sister) in their life when they do not feel well. Even in hypothetical situations in vignettes, the children often referred to their mothers. When asked why they relied on their mothers, Mina, an eleven year old in class six, pointed out that:

'You know eh, mothers are the ones who give birth. They are the ones who feel the pains when they are giving birth and so when you are sick they can be worried. They feel the pain and so they understand.'

In addition, ten-year-old Charity said that:

'When a woman goes to give birth, it is fifty-fifty. Either she will give birth or she will die. Or she can give birth and the baby will die. So she will take it serious when you are not well. Because... eh she is the one who is feeling the pain.'

In a context where maternal mortality is prioritized in the policy agenda (see Kyei-Nimakoh et al., 2016; Adika et al., 2017; GSS, GHS and ICF, 2018), it does not come as a surprise for the children to view mothers in terms of dying while giving birth. It is also apparent that mothers are associated with childbirth but most especially the pain that comes with it. It can thus be inferred that the children see mothers as people who experience childbirth and the associated pain and so have the capacity to understand or feel whatever pain it is that they feel when they do not feel well. It further appears that the children expect some empathy from mothers because of what they go through during childbirth.

Again, the children in this study associate mothers with empathy and care. They are of the view that a mother is someone who can empathize and show care when one is unwell:

Mothers are caring and they can also sympathize with you when like your head is paining you and you tell her. (Nine-year-old Beatrice).

This view of mothers is further transferred to teachers in school and so children look for such qualities in teachers that they report not feeling well to, as illustrated in the previous chapter:

Most times I tell Teacher S because he is caring like a mother and will help me when I am not feeling well. (Ten-year-old Adiya).

In addition, the children view mothers as the parent who is usually available at home. That is, either a stay-at-home parent or the one with flexible work hours. It then seems that reporting not feeling well to mothers is a matter of convenience in some instances:

Me it is my mother who is always in the house, so if I even want to tell my father but he is not in the house. He is very busy. Sometimes if I even tell him he will still say that my mother should take my health insurance card and send me to the hospital. (10-year-old Abigail).

In this way, it is clear that for some children, mothers are the ones they can easily get in touch with when they have a problem. The ease with which they can reach mothers then becomes for them a convenience for reporting not feeling well to their mothers. As pointed out in the previous chapter, mothers are the ones who mostly do school runs, and they are the ones the children work closely with. They are thus easily available and so children rely on them when they do not feel well.

Some of the children ascribe specific roles to mothers at home and so this becomes important for them when deciding who to report not feeling well to. They are of the view that mothers are the ones who take care of everyone in the house including the sick while fathers provide the money to cater for health needs:

I always tell my mother because she is the one who will take care of you. My father will give her the money when we are not well and then she will then go and buy the medicine or take a car and we will go to hospital. (Nine-year-old Dery).

Or in the case of eleven-year-old Percy:

When we are sick my mother will collect money from my father and buy medicine. Sometimes if my father is not in the house she will call him and say that I am sick so he should buy medicine...when my father bring the medicine, she will take it and pour it for me to drink.

It is reasonable then to assume that the children map out some kind of division of labour from how things are done within the home. In interactions with the children it was not uncommon for them to say that their fathers will usually ask that they report to their mothers when they do not feel well. Their mothers in turn will take them to either the pharmacy or the hospital when it becomes necessary. For some of the children, their mothers usually call to inform fathers about their child not feeling well and then in some cases, the fathers will provide the resources for the mothers to deal with the illness. Each person then has a role to play and so sticks with it, as eleven-year-old Rashad asserts:

Even if you tell my father, he will still say that you should wait for your mother to come and you will tell her. So sometimes even if my mother is not in the house, I will wait and then when she comes I tell her... Like one time my mother travelled for three days but I still wait for her because she is the one who will take care of you if you are sick.

Arguably, children rely on the ways in which their context views mothers as making decisions about not feeling well. In line with this, Alanen and Mayall's (2001) concept of generation, which suggests that individual children and adults interrelate across age divisions, power inequalities and household norms and needs, becomes useful. It appears that the children recognize the socio-cultural norms and values that govern the way things are done within the household because it is their lived experience. Again, the father's economic status as the one who provides monetary resources for the household allows for some kind of division of labour. The mother then becomes the provider of care. This results in some sort of power imbalance; children have to rely on mothers and mothers have to rely on fathers but in the end the fathers have the upper hand

as they have the authority as the heads of household to shape the actions of both children and mothers.

While children hold these views about mothers, mothers themselves hold notions about who and what a mother should be, and this also influences ways in which illness complaints are dealt with. The next section discusses this.

7.3 Mothers' ideas of themselves and how this reflects in their responses to children's claims of feeling unwell

During my interactions with mothers, what resonated with almost all of them was their insistence on motherly instincts. Being a mother, in their view, comes with some kind of natural skill. Those who hold this status seem to automatically acquire it:

You know these things [whether a child's complaint is true or not] once you become a mother...I don't know but it just comes natural and you can tell whether there is something wrong with the child or not. (Sumaya, mother of three).

Another mother had this to say:

As a mother, you can always tell from the signs. It isn't that you can't make a mistake but you just know these things. You'll understand when you get there [become a mother]. Trust me. (Agnes, mother of four).

In conversations with children, they often made remarks about their mothers that reflect this view mothers have of themselves:

When me or my small sister [younger sister] is sick, and my mother does not agree...she will say that she is our mother and she is the one who will know whether we are sick or not (Nine-year-old Vielong).

Feeling the pain and seeing the pain

Another child remarked that:

I always tell my elder sister when my mother says that it is not true [does not believe her complaint of feeling unwell]. Then my sister will convince my mother that it is true and that it is not that I want to be pampered and my mother will say that why? Are you now the mother? I know it when Maame is really sick. (Eleven-year-old Maame).

Mothers hold notions about themselves as entrusted with the responsibility of ensuring that their children look their best, feel well and are generally viewed by others as being well catered for, and:

...not only when they are sick. In fact you have to make sure that they eat well, they are clean and that they are good children. You are the one everyone will see [blame] if the children are seen as anyhow and not looked after well. (Pagnaa, mother of three)

In relation to this, I observed teachers question the children, when they considered them unkempt or not dressed properly, about the whereabouts of their mothers at the time they left home for school:

Did your mother see you this morning before you came to school? Why didn't she wash your shirt aahh? Where did you pass to school? Where was your mother ahhh? Tell me! (Male teacher).

Further the need to be 'good' mothers was shown in ways in which mothers initially responded to questions about their experiences with children complaining about not feeling well. Most of the mothers stated that their children rarely fall ill. The stance of mothers reflects the importance of children's health to 'good mothering' (Prout, 1988: 770). In Prout's study, mothers made an effort to show themselves off as performing their motherly duties of care as best as possible to him, a male stranger who was inquiring about this. However, as his study progressed and some familiarity was established, the mothers admitted to having children complain about feeling unwell. Prout (1988) suggests a test of

this scenario by a female researcher to see to what extent mothers will defend their role as mothers. The mothers I encountered were also initially defensive, and when they accepted that their children had complaints about feeling unwell, they blamed external factors beyond their control. For instance, the mothers in my study attributed the illness claims by the children to the time of the year or the season:

Ah yes. The mosquitoes during the rainy season is too much. So like my daughter, the rainy season is the time she complains most. Today here, tomorrow there and so on. The weather is not good for them at this time of the year (Regina, mother of two).

Again, school schedules were often blamed for children's claims of feeling unwell:

When school reopens they worry us a lot. Today this, tomorrow that, tomorrow next this. School makes them tired. They [children] are more than officers. By 6.30 to 7 in the morning, they are already in school and they are there until 4 or even sometimes 5 because of extra classes before they come home. Especially the little ones. What will they be learning from 8 till 5? (Sumaya, mother of three)

In addition the mothers largely qualified their children's illness complaints as 'common' or 'usual' sicknesses that children have:

It is the usual headache, stomach ache, body pains. Those common sicknesses. That is what they [children] are usually disturbing you with. (Regina, mother of two).

Mothers relying on the weather and school schedules could perhaps be a way to absolve themselves of any blame for their children's ill health. I further assume that mothers qualifying the complaints as common could be a way for them to state that they are good mothers and perform their motherly duties well, and so if their child came with a complaint, it is the 'usual' one that every child has and not necessarily peculiar to them.

With regards to their status as mothers, they also indicate that they know their children very well since they spend the most time with them, and so this helps them make accurate decisions about whether a complaint is real or not:

See you sleep in the same house with them and so you'll definitely know their likes, dislikes, moods do you understand? So it's like that. Every child is different ooo so once you know who or how your child is then there is no problem. (Regina, mother of two).

When mothers were asked about making mistakes about the child's claims, a mother had this to say:

Maybe I'm yet to experience that. I haven't been wrong yet [laughing]. (Ajara, mother of one)

They also indicate that they are able to see the pain their children are going through when they complain about feeling unwell:

When my daughter is seriously sick you see the pain she is going through, she won't eat and she becomes so attached to me. I cannot know how she is feeling but I can tell she is suffering. (Ajara, mother of one)

It stands out that while mothers express the view that they can 'see' the pain their children are going through, children on the other hand expect the mothers to 'feel' that pain. These two are however not the same, and so there is a disjoint between children's expectations and mothers opinions concerning the children's illness experience. This becomes a source of tension between mothers and children. There is a detailed discussion of this in a subsequent section of this chapter.

From the following analysis, it is obvious that mothers believe their children feign illness sometimes in their claims. However, they also believe that the notions they hold about themselves such as '*motherhood being natural*', '*having motherly instincts*', '*having knowledge of their children*', and the '*ability to see a child's pain*'

help them make the right decisions about these claims. The mothers in Prout's study expressed similar views about themselves that enable them to deal with their children's illness claims (Prout, 1988). The point of departure however lies in mothers' additional consideration of what Prout (1988: 774, 776) describes as emotional upset and training in stoicism. That is, the mothers in his study considered emotional disturbance and the view that contemporary children are weaker in their personalities making them soft and easily willing to give in to their feelings of not feeling well. This position was not observed among the mothers I encountered. Mothers assume a status they consider different from children and so rely on this status as the parameter within which to test and to ascertain the illness complaints of children.

I now turn attention to teachers and how their views and experiences as mothers come into play when dealing with children's claims of feeling unwell in school.

7.4 The experiences of teachers as mothers in dealing with children's complaints of feeling unwell

Mayall (1993) has pointed out that not only are teachers concerned with fulfilling the school curriculum, but they are also engaged in care work at school. This holds true for the teachers that were observed and engaged with in this study, especially the female teachers. Apart from children looking out for qualities in teachers that resonate with what they believe mothers should be, teachers also rely on their experiences as mothers in dealing with children's complaints of not feeling well. There are two ways that this is done. First, female teachers use their own experiences with their children as a guide for how to respond to children's complaints about feeling unwell:

My own son, who is almost 7 when he is sick, he behaves normally. There was a time we didn't sleep because he was running a temperature throughout the night and very feverish. I was really worried and the next morning I immediately rushed him to the hospital. While waiting to see the doctor, he was running around the whole place and touching every single bench and chair at the hospital yet his temperature was high. You won't believe that it's the same person not well. So

some of these children they act normally until they are probably given a drug which knocks them off. So it'll really be a bad idea to assume that once they are playing they are well. (Female teacher with two children).

Others also use this experience as a way to judge whether a child is genuine in their complaint or not:

See for instance my own daughter Araba. I know she is not in the age category you are looking at. That girl is a chronic lazy girl! The way she punished me eh. She'll wake up today 'my chest', tomorrow 'my heart is beating too fast and I can't breathe' and all sorts of things. This went on for a long time and finally my husband and I decided we should take her to the hospital for a check-up...nothing was wrong with her. So sometimes these children are just avoiding things they don't want to do. (Female teacher with four children).

The second way in which teachers rely on the experiences of mothers in dealing with children's claims is for male teachers to refer children to female teachers who are also mothers when they complain of feeling unwell. These teachers refer general complaints of the children to a female teacher:

For me I usually let the children go to Teacher A...she has children and she will therefore have the capacity to assess and help them better. As for me I am just a bachelor, what do I know? (28-year-old male teacher).

They also make such referrals in other instances, such as when they suspect that a girl complaining about stomach ache could be cramps from her period:

You know girls and their issues [having periods]. When the girls especially come and tell me their stomach is aching I just refer them to Teacher D. She is a woman and has her own children. She will know what to do better than me. It is somehow awkward to me if it happens that maybe she is in her menses. I won't even know what to tell her. To be safe I just let them all [boy or girl] go to Teacher D. It is helpful that way. (32-year-old male teacher).

However, in one instance there was a male teacher who most of the children reported complaining to when they feel unwell. When he was asked what the reason was since it appeared it was a domain for female teachers, he answered thus:

You know these things [illness] need someone who is patient, can sacrifice his or her time and is caring. I have my own children and I see these children like my own. I don't mind helping them because I do it for my children. (47-year-old male teacher).

This illustrates a departure from the pattern that was observed even among male teachers who have children. While this demonstrates that some male teachers engage in dealing with the illness complaints of the children, the emphasis of the teacher on '*patience*', '*sacrifice*' and '*care*' still goes to show that the attributes assigned to mothers play a great role in the teacher's involvement.

The values that some of the teachers who have no children aspire to hold when they have children is also brought to bear in dealing with the children. They assume the position of a mother and use that to form their decision concerning a child's complaint:

...If I were a mother and you a teacher let anything happen to my child because you didn't believe him I won't take it lightly at all. So I do what I'll want someone else to do to my child. It is better to give them benefit of doubt than to say no and have problems with their parents later. (Twenty-six-year-old female teacher with no children).

Another female teacher who has no children yet was also of the view that:

...so I will suffer and have my child and you a teacher will use your decision to cause trouble for me. No I won't take it. I know we are all human and we make mistakes but I want children who will be open and can tell me anything so if their opinions are rubbished that purpose will be defeated. I don't want yes sir! yes sir! children [children who agree to everything without questioning].

Not only does this view reflect how these teachers deal with the children but also the ways in which children are conceived in a context where there is a wide perception that the relations between children and adults is strictly hierarchical (Twum-Danso, 2009; Boakye-Boaten, 2010; Adu-Gyamfi, 2014). The stance of the teachers may show that these dominant perceptions are changing. It is also worth noting that these observations were made of teachers in the school with middle class children. I presume therefore that these teachers observe the relations between parents and children and also the nature of interactions that go on within the school and so aspire to such values for their own children, which may in turn have consequences for child-adult relations over time.

It appears that even within the confines of the school, care work takes place. This is rooted in the roles mothers play. Although performed by different people (teachers), dealing with illness still largely lies with mothers and with attributes that society ascribes to mothers. In what follows, I present the ways in which notions about mothers and children play out and form the processes involved in children's complaints of feeling unwell.

7.5 They do not hear it in public: Ways in which mothers and children negotiate feeling unwell

Although children and mothers seem to have similar views of who mothers are and the ways this influences how they deal with illness, I must point out that this does not necessarily translate in the same ways both of them make meaning of the child's claim. Further, the discussions so far seem to paint a kind of straightforward picture of dealing with children's illness. That is, a complaint is made and then mothers respond by using abilities acquired by virtue of being mothers to respond to these complaints. However, this is not necessarily the case as tensions and conflicts do arise between children and mothers in dealing with claims of illness. For instance, as indicated earlier, children expect mothers to 'feel' their pain while mothers point out that they 'see' the pain. These are both subjective tendencies and only meaningful to the individual engaged in or experiencing it. In this way, children usually feel entitled to their claims, because it is their 'body', and their 'pain' and so expect that they should be acknowledged:

It is my head that was paining. It is my head and I know because hmmm... it was my own head. But my mother said that I am telling lies. That I don't want to wash the bowls and that it is because I have seen many people in the house [cousins were visiting] that is why I think that someone will be doing my work [washing bowls] for me. Hmmm...but it is not true. (Eleven-year-old Anatu)

Eleven-year-old Sherifa explained:

As for me my mother will say that it is not true. That I am not sick. But I am feeling the pain ooo [emphasizing] and she will still say I should sweep. I will cry and go and sweep and go and tell her again but she will still say no. I will just give it to God [let God judge if she is being truthful or not]. (Ten-year-old Zinny)

Mothers on the other hand want to see visible signs of the claim before they accept it as truthful:

Someone whose head is aching and she is running around and playing. She is just seeking attention...or she will come and cry my stomach, my stomach meanwhile she is eating left and right (anything in sight). I don't even mind her. If she is really sick I see it. (Ajara, mother of one).

In this situation, some children indicate they persist and insist on their claims until their mother becomes fed up and listens to them:

...small time [after a while] I will tell her again. Then when she was in the kitchen I went and told her my stomach is still paining and she say that I should go to toilet. I went and it was still paining me and I tell her that it has not stopped. She enter our room and pick Aludrux [magnesium trisilicate] and gave it to me that I should chew it and drink water. (Ten-year-old Nommu).

Others point out they allow things to take their own course:

I told my mother that I am sick and she didn't mind me. So I go and sit down and small time [after a while] I tell her again and she say that I am lying. I went outside

and cried and the next day, in the night when we were sleeping my body was hot and I couldn't do anything so my mother hurry and take me to the hospital...they admit me in the hospital that night. (Ten-year-old Cindy).

On the part of mothers, however, they indicate treading with caution—or as one mother called it, applying '*an extra sense*'—when dealing with these claims. It was thus not surprising that when I asked mothers to recount times that their children have complained about feeling unwell, it was often met with a mixture of laughter, sighs and shaking of the head. Mothers believe that you have to always be a step ahead of children in order not to be deceived or fooled by them because these days, children are very '*smart*'. They also believe that they are the mothers and so the children should not and cannot take them for granted:

Is it me or him [child] who gave birth to the other? So they [children] cannot fool me. We know all the tricks. I was not born yesterday [laughing]. You must have an extra sense to deal with these children (Pagnaa, mother of three).

Other mothers rely on their knowledge of their children — as pointed out in the previous section — as a way of ensuring that children do not '*fool*' them with claims of illness:

Oh not always. Some of those complains are tricks. She thinks she is smart. Either she doesn't want to get her hair done, she wants you to buy some things for her or she just wants to be pampered. When she is really sick I know. She doesn't have to tell me. (Ajara, mother of one).

It emerged that it is in these tensions and disagreements over children's claims that children devise their own ways of dealing with their ill health sensations, as illustrated in previous chapters. Mothers however believe that they are right because they specify that in most cases the complaints cease even without any interventions from them. Using my knowledge of what the children had told me about their use of medicines, I created hypothetical scenarios in conversations with mothers about children using medicines to help themselves if their claims are not believed. The mothers I interacted with were quick to point out that their

children will not do things like that. This situation presents a dilemma as there is no exact blueprint of what should constitute a genuine complaint and one that is not. However, outside of a formal health establishment, the responsibility largely falls on mothers to make these decisions and take the necessary actions.

In the midst of these disagreements, data from the study show that several factors are involved in the ways in which children and mothers deal with complaints about feeling unwell. That is, accepting the claim, reframing the claim or rejecting it entirely. I have organized these factors into four broad themes, namely: i) the space in which a complaint is made, ii) the need for a social obligation to be met, iii) the child's past illness history, and iv) visible signs in relation to the personality of the child.

7.5.1 Space in which a complaint is made

With regards to the space in which a child's complaint is made, I use the mother's terms of public versus private space. Mothers consider the school and any other place outside the home as a public space including church, parties, marketplaces and gatherings of family and friends. The home however remains a private space in their view:

Places like the market, school, church, wedding or a place that you and your relatives are together. Ehhm like even funeral, there people can see you and talk about the things you do or don't do. So, that one is public. But everything I am doing in my house is my private matter and it doesn't concern anybody. (Agnes, mother of four)

Another mother is also of the view that:

The things I am doing in my house is my business. So no one can come and tell me what to do. It is private. But outside it is not the same. Many people will have a view on what you should do. (Ajara, mother of one).

In conversations, mothers indicate that responding to a child's claim of feeling unwell works differently depending on this space. Some mothers emphasize the

need to proceed with tact when dealing with their children in public, including their illness complaints, because:

People are watching and will say all kinds of things about you. So you will also have to be careful before someone thinks that you do not care about your children. (Pagnaa, mother of three).

For most of these mothers, people in the public space will have varied opinions about their child's complaint. Either people will see you as insensitive if you write off the claim or being too indulging as a mother if you take every claim seriously. Meanwhile they as mothers know their children better. They are then forced to navigate this dilemma and to make a 'right' decision so that they appear acceptable in the eyes of the public. Some mothers were of the opinion that their children seem to know this uneasiness and some of them use it to their own advantage to get their own way:

They [children] do not hear it [when their claim is dismissed] in public and everyone around thinks that you are a bad mother or you are not feeling for them [being insensitive towards the child]. They know this and so they will use it when they are outside with you and say that one place or the other is paining. (Agnes, mother of four).

In the same regard a mother had this to say:

When they call you to the school to pick your child because he is sick it can be difficult. In the middle of work, the inconvenience, but you have to go because if you don't they would start pointing fingers at you and forming opinions that you do not have the child's welfare at heart. It is not that simple. We know these children and what they can endure. So sometimes it is unnecessary but you have to go. (Sumaya, mother of three).

Further in the public space, options are limited:

When you are out like this and the complaints start coming, you cannot tell them to go and lie down for you to see if it will stop or not. They will let you buy all sorts of foods and drinks because they are sick. (Agnes, mother of four).

Mothers may not be able to instruct a child to go and lie down or relax as a way to *'wait and see'* if the complaint is genuine. It is conceivably then that the public space is not one most mothers would want to be in when dealing with their children's illness. At the same time it also works well as a space for a child's claim to be entertained to some extent. It is however dependent on the extent to which a mother is concerned about public opinion.

For lower class families this dichotomy between public and private space is largely blurred. This is because most of them live in compound houses with shared facilities and the only time that privacy is observed is inside the bedroom. Thus activities from bathing to cooking are performed in the full glare of their neighbours and so they share to some extent this private space with neighbours. In this instance neighbours can act as promoters of a child's claim:

I told my mother my stomach and my head is paining and my eyes too were turning [feeling dizzy]. But she say that it is not true. Then one of our house people [neighbour] their door is next to our door, she tell my mother that when I came back from school she saw me vomiting. (Ten-year-old Feruza).

However, they can also act as a barrier to a child getting their claim accepted:

Some man he is living in our house, it is a big house with many people, they and their children and some university students. When I tell my mother that my head is paining then he say that now now [just a while ago] we are playing and running about and now I am saying that my head is paining. But it is true that my head is paining but my mother did not mind me. (Ten-year-old Abass).

7.5.2 Meeting Social Obligations

Parents (mothers) believe that their children should be involved in and take seriously certain social obligations such as going to school, attending Quran recitation school (Kareem) during the weekends, attending church services and taking part in some household chores. Some parents acknowledge that their children can be overwhelmed by these obligations and use illness as excuses to avoid them:

Most times they beat them really well at the kareem when they are unable to recite the verses well. It is also a form of discipline. Some of the children, my daughter for example find the Arabic really difficult to muster but she has to learn it as a Moslem. But when she cannot handle it she will be using sickness as excuses not to go. What kind of person falls sick only on Saturdays and Sundays [days for the recitation]? Tell me. We all went through it and we are fine. (Hajia, mother of three).

Some teachers also suggest that some children are not interested in attending school and so manifest this in their illness complaints:

But I know what I am talking about. If you compare Linda's behaviour here in school and at home you'll certainly know that she doesn't like school. I spoke to her parents. How come she only falls sick when she is in school and not at home? And how come she is only sick during class hours but not the time when she is waiting for her parents to pick her up? (Marilyn, a female teacher).

In addition, some mothers believe that their children are lazy and so feign illness to escape household chores, which are in their opinion essential training for life. This is especially so for girls who, in a patriarchal society like Ghana, are largely expected to be socialized to take charge of household chores in the future:

Because of laziness my older daughter will look for the least opportunity to complain that she is sick when you ask her to do house work. But you know she's a girl and she needs to learn basic things like cooking and cleaning. When I am not there who will do it for her? (Sumaya, mother of three)

Parents' notion of children as '*becoming*' or beings in the making is manifested here. Not only are they supposed to be children but they are also seen as projects to be prepared for the future. Mayall (1993) and Christiansen (1998) believe that the views parents have about their children largely determine how the children are related with and responded to, and this is obvious in the ways in which the children's illness claims are regarded. In addition, it is noteworthy that when a social obligation is involved, parents (mothers) reframe their children's illness claims as largely reactions to the perceived difficulty of their obligations as children.

7.5.3 The child's past illness history

There are several sides to this: a child with an existing medical condition, a child who has stayed in hospital in the past, a child who often complains of feeling unwell and a child who hardly complains about feeling unwell or hardly falls ill.

A child who has an existing medical condition such as asthma or sickle cell anaemia seems to be one who does not have any difficulty in making a claim of feeling unwell. Such a child is usually closely monitored and any complaint is treated with urgency. Children in this category express frustration about how their parents seem to expect that they will fall ill:

When my mother came to pick me, Teacher M told her that today I played football. My mother asked me why I played but I didn't say anything...in the house I was doing my homework and every small time [from time to time] she will come and look at me and when I was going to sleep she asked me that am I feeling okay but there was nothing wrong with me. She likes doing that and I don't also always like it. (Kelvin, ten-year-old boy with asthma).

In a conversation with a mother of a nine-year-old girl with sickle cell anaemia, she points out that:

Look, even if what she says it's not true I don't joke with her complains. You know with someone like her you always have to look out for any signs at all. She has crisis from time to time but even common headache can mean a lot of things.

So I try to ensure that she rests and thankfully the school knows and I told them to always call me or the father if she says she is sick in school. (Nancy, mother of one).

For such children it is arguable that they do not need any extra effort to make their parents believe their claims of not feeling well. Whether they complain or not, parents constantly keep an eye on them to ensure that they feel well. Christensen (1998) finds similar patterns in how children's competence is negotiated in pharmaceutical use. The competence of children with chronic ailments in her study who had to use medicines constantly was not only seen as different from adults' but also from normal healthy children. So an existing medical condition becomes a loophole for a child in navigating the process of establishing the status of being ill to adults because they already possess such a status. While this seems to lessen the child's effort in exerting competence, contrary to Christensen's study it appears to some extent a burden for children with an existing medical condition in my study because they are constantly monitored and watched.

Beyond an existing medical condition, children who have stayed in the hospital in the past also seem to stand a better chance of having their illness claims accepted:

Now when I tell her she will believe me. It is because of the time that I was sick and she said that I am telling lies and one week time [later] they admitted me at the hospital and gave me blood and water [drips]. She was not happy that she didn't know I was really sick. So when I tell her she will say that it is true...but I always tell her the truth. (Ten-year-old Cindy).

Mothers also blame themselves for the time they did not believe their child and then later the child had to spend some time in hospital because of the same complaint:

Hmmm... I won't forget the day my daughter kept complaining that her stomach was paining and I told her it was the beans she ate and that when she goes

to toilet she will be free [relieved]. The next day same thing but I didn't mind her because I knew she just wanted attention...my sister we finally ended up in hospital the night of the third day and spent two weeks, my sister two weeks in hospital! If anything had happened to her, God forbid, what will I have done? So for me it depends, I don't think I can ignore anything she tells me again. (Regina, mother of two).

It appears that believing the child's subsequent claims of feeling unwell is a form of atonement for the earlier mistake which took them to hospital. It would also seem that mothers feel like they would have failed their children if anything untoward happened to them because they as mothers are entrusted with the care of their children and yet did not believe them when they should have.

Again, a child who often claims to be feeling unwell is usually not taken seriously compared with one who hardly complains or is not known to fall ill often. For children who complain often, adults soon consider it a habit of the child and so the child is taken less seriously and the claim rejected:

My eldest son, I remember when he was in class four eerrm or is it five [he is now in junior high school] everyday Mama my stomach, tomorrow my head, and so on. A time came I just won't mind him and I told him he should be behaving like that boy in the story who cried wolf...when the wolf finally came there was no one to help him. Sometimes you have to be hard on them to stop some habits. He is a boy too and he is behaving like this. (Pagnaa, mother of three).

For those children who rarely fall ill or complain, they are likely to make a successful claim of feeling unwell:

Oh but most times I believe my children. They hardly fall sick so when they tell me they are sick I believe them. They don't complain all the time. They are mostly fine. (Agnes, mother of four).

Some of the children know this but insist that they really feel pain or feel unwell when they complain:

Teacher S told my mother that as for me every day that my somewhere is paining and my mother said that I am like that. That they [teachers] shouldn't mind me and that if I am not learning they should cane me but it is true that I am sick. (Maame, nine years old).

During a focus group discussion with girls in class five, one child supported by the other discussants stated:

Teacher always say that we the girls we like complaining. Any small sickness we will complain but me when I am sick it is true. I don't even like medicine so I won't tell lies. (Pamela, ten years old).

The children feel that when they complain all the time it is because they genuinely do not feel well. However, both teachers and parents think otherwise. A child who complains all the time is soon considered not serious and so this affects the child's credibility when it comes to making claims about illness.

7.5.4 Visible signs and the personality of a child

A myriad of options are used alone or in combination to check the genuineness of a child's complaint. Mothers often look for visible signs when there is an illness complaint. This could explain why children are very concerned about concrete signs in making sense of illness. The mothers I interacted with seem to have general unwritten rules for testing a child's claim of feeling unwell. When a child reports not feeling well, they look for bodily signs such as very hot body temperature, lack of appetite and vomiting:

Oh for instance if she is really sick her body will for example be very hot, she will be vomiting and sleeping a lot. She will also not want to eat. Things like that. (Ajara, mother of one).

Further, they pay attention to the duration of these signs. The persistence of symptoms means it is likely to be accepted that a child is truly ill. Christensen (1998) observed that adults constitute themselves as competent by drawing on 'rational knowledge and mediating devices' such as the duration of time and

the thermometer to classify children's mental and bodily experiences as 'real' illness. This means that children's competence is suspended by adults. In the context of my study, however, the 'mediating device' is a subjective action that is used to determine the state of a child's body as truly experiencing what the child says it is. From children's descriptions and personal observation, adults usually touch their forehead or neck to check the body temperature. This action, although subjective, takes precedence over the child's equally subjective claim.

While using these criteria, mothers also consider the personality of a child – that is, how the child is on a day-to-day basis. A break in habit is viewed as problematic:

Let's say for example my little girl is a foodian [has a great appetite]. She eats like the world is about to end [laughter from other mothers] and so of course when she is not eating then something is wrong. For instance, there was a time we went for a friend's birthday party. There were all kinds of food and cake but she was not excited to see the food. Eihh see chicken, see malt, see sausages and jollof rice which are all her favourite but she wasn't moved. Then I knew I had to be worried. Adwoa [daughter] has seen food and still no shaking [no excitement] and truly later in the day she had high body temperature and was vomiting... we later had to treat malaria (Regina, mother of two).

Another mother also shared the following:

My son is the 'gidigidi' [very active], cheerful and playful type of child but when he is really sick he'll be quiet and very dull. Also he eats any and everything. But the moment sickness set in if you want cook his best food but he won't touch it. I never had problems with him eating right from when he was a baby but when he is sick, no matter what he won't eat. So it is not about whether we believe them or not but it is about knowing your children. (Agnes, mother of four).

Others however express caution about relying on the child's personality to make decisions about them not feeling well:

So you cannot treat all the children the same otherwise it won't work. My elder sister's 'baby last' [a term for last child] for example she is active even when she is not feeling well. She will still play, eat normally and all. So such a child you just have to be watchful of them and use their body temperature to tell if they are not well. It can be hard but once you get to know your child then that's it. All of them and their personalities. (Ajara, mother of one).

In addition, some mothers state that they threaten or test their children with medicines and injections. In their opinion, when the child is truly ill, he or she will accept the medicine; otherwise, the child's disposition changes and the claims are suspended:

When my daughter starts her usual complains, I'll just ask that we go to the nearest pharmacy for injections... then you will see her suddenly active and the sickness will vanish. When I insist and act like I'm getting ready to take her to the pharmacy, she will disappear (laughing). (Ajara, mother of one).

Another mother in support of this adds:

Oh yes, that thing [threat or suggestion of medicine] works really well. All of sudden they are no longer sick. Then you can have your peace of mind. (Sumaya, mother of three).

However, in interactions with the children, some of them indicate that they do not like medicines, especially when they are bitter:

...I told my mother that it seems I was getting malaria and she said that it's because I don't want to work but even me I don't do plenty [tedious] work like cooking because I'll burn it. Then she said we should go and they will give me medicine for the malaria but I refuse because the malaria medicine is very bitter. (Feruzza, eleven years old).

Using this criterion then may not work for children who genuinely have illness sensations but do not like medicines. From the discussions, it is obvious that

children's illness complaints are not easily taken at face value. There are a combination of checks and possibilities for determining the genuineness of a child's claim. This process is not straightforward and involves ongoing negotiations between children and mothers.

7.6 Conclusion

This chapter mainly discussed the results of the study, which reflect the circumstances under which a child's perceived sensation of feeling unwell is resisted, reframed or accepted by mothers. The highlights of the chapter are that dealing with children's illness complaints is rooted in characteristics mothers are believed to possess by children, teachers and mothers themselves. These characteristics include feeling a child's pain, seeing a child's pain, being caring, making sacrifices and empathising.

Although children have been shown to have the ability to exert influence in constructing and dealing with their illness, this ability is challenged by mothers leading to tensions and conflicts in the ways in which illness is dealt with. This is because of competing interests between children and mothers. For instance, while mothers have an interest in preserving their status as mothers through healthy children, their children distort this interest with illness complaints especially in the public space. Again, mothers expect their children to fulfil their social obligations such as going to school and performing household chores but children are seen as not cooperating when they complain of illness. In the midst of this, several possibilities are engaged to deal with illness. While children insist on their claims of feeling unwell, mothers and teachers reframe them as strategies to avoid their social obligations. At other times, children's claims are tested using parameters such as visible physical signs to resist or accept them. The most likely situations in which a child's claim is accepted is through a child's persistence, the presence of an existing medical condition, a child who is rarely ill, and a previous encounter with a formal health institution.

Considering children's and mothers' relations in dealing with illness the concept of generation enables an understanding. It is apparent that children and mothers

belong to distinct social groups, that is, the social group of children and the social group of adults. Their interactions are also shaped by different interests and needs, all shaped by social norms and policies (Alanen and Mayall, 2001). In addition, mothers belong to a different generation from children and carry with them knowledge, assumptions and experience that they have acquired over their lifetime and influenced by the social forces in place in their lifespan (Alanen and Mayall, 2001). However, I argue that in certain circumstances, such as a child with an existing medical condition, these divisions, interests, policies and knowledge are suspended by mothers, allowing the child's subjective knowledge of themselves at that moment to take precedence. Although informed by a professional diagnosis (existing medical condition), it shows that a certain status of the child enables competence and a recognition of this competence in child-adult interactions.

It has been made apparent in this chapter that children and adults (mothers) have differing outlooks about children's illness sensation. It is necessary then to turn attention to how children and adults frame these sensations; that is, what and how they are named and the interventions resorted to.

8

Conceptualizing and framing children's complaints of feeling unwell

8.1 Introduction

In the last chapter, I highlighted ways in which children and adults – largely mothers – perceive children’s complaints of feeling unwell. It appears that children and mothers have different outlooks on illness complaints and this influences the ways in which the complaints are negotiated. Given the differing outlooks that adults and children have, this chapter focuses on the ways in which these illness sensations are conceptualized by children and adults. That is, what and how sensations are categorized and named, and specifically: what and how are medical categories or treatments used to frame a child’s illness complaint? Relying on data from conversations with parents and teachers, interviews, focus group discussions and classroom interactions with children, I illustrate ways in which children and adults differ in attaching medical categories to illness experiences. In addition, I show how interventions and treatment options are influenced by the categorization of illness that is relied on. In doing this, I pay attention to whether and when everyday experiences and practices are problematized or not.

8.2 Conceptualizing illness: the child’s perspective

In previous chapters, I pointed out the ways in which children make sense of their sensations of illness. It emerged that children rely on several avenues such as self-reflection, the media, the home, their peers, and lessons taught in school to make sense of and deal with these sensations. What stands out however is that children, to a large extent, have an unvaried way of conceiving their sensations of feeling unwell. They follow a kind of straightforward criteria for categorising what they feel:

My head was paining me and my body was hot. My mouth was bitter and I didn’t like any food again because I will vomit it. Then I started feeling cold too and I went and wear my pullover and I was shivering. My knees and my hands, there was pain inside [joint pains]...I am having malaria again. (Ten-year-old Aziza).

Another ten-year-old boy, Aziz, further illustrates this:

All my body was paining, even water I can't drink it. My friends were playing football but I tell them I cannot play so they should play and leave me. I go and lie on my table but it [body] was still paining me...I think that it is malaria.

The children mainly frame their sensations under medical categories such as malaria, diarrhoea, typhoid and Apollo (eye infection). Although they rely on a number of signs and the persistence of those signs (illustrated in chapter five), they ultimately explain these feelings more as a biological phenomenon. This finding is closely related to observations made by earlier studies that explored ways children conceptualize illness (see Mouratidi et al., 2015; Piko and Bak, 2006; Buchanan-Barrow et al., 2003; Van Reeuwik, 2001; Schmidt and Frohling, 1999; Charman and Chandiramani, 1995; Springer and Ruckel, 1992; Campbell, 1975). However, in most of these studies, children were presented with named diseases including but not limited to diarrhoea, AIDS, chicken pox and asthma. My study shows that even with unnamed illness, feelings and vague complaints of feeling unwell, children are still more likely to rely on biomedical categories and dimensions to conceptualize their experience. Wasike (2007) observed among Ugandan children that supernatural dimensions such as 'bad winds' in the bush at night were employed in conceptualizing fever. However, this study did not encounter any supernatural explanations for feeling unwell.

Further, Moratidi et al. (2015) observed in their study of five- to eleven-year-old children that as children get older they also perceive illness within lifestyle habits. In contrast, the children in my study whose ages fall within the older children category (nine to eleven years old) of Moratidi et al.'s study hardly referred to lifestyle habits in the framing of their illness. This finding contrasts the view that as children get older they attribute illness to some lifestyle changes. There were however instances where the children considered influences in the environment as contributory factors to why they feel ill. Even within these influences, they relied on germ-causing or disease-causation patterns within the environment:

I know that I have malaria because a lot of mosquitoes bite me when we went to all night [vigil service] at our church. (Eleven-year-old Monica).

Again another child indicates that:

The rain beat us when we were going home. All our uniform was wet. In the house I was feeling cold. The next day when I come to school my head started paining me [headache] and I was feeling cold...it is because of the rain and the cold that is why I am sick. (Ten-year-old Martin).

Viewing their sensations of illness in this way influences how the children deal with them. They rely on medicines as a remedy for their feelings. In conversations, children emphasised the use of medicine and the importance of it to restoring their health:

Me, I take Gebedol [painkiller] when my head is paining me. When I take it now now now [immediately] my head[ache] will stop. We have some in the house so anytime I want it then I'll just go and take it (Eleven-year-old Baba).

Some also expected medicines any time they feel unwell and complain to their parents or teachers:

Even when I told my mother that I am sick, she did not give me medicine. She say that I should go and lie down. Then I was still sick but she still did not give me medicine. (Nine-year-old Rafi).

From the data, it is obvious that the children view illness and its related sensations in dimensions that are biomedically oriented. They do necessarily seem to present their illness sensations as a multi-faceted phenomenon. As a result they rely on biomedical interventions such as medicines to deal with their experiences. They also expect the adults they report not feeling well to, to use medicines as their response to their complaints. If this does not happen, children feel that their needs in relation to not feeling well are not adequately met by adults.

As indicated in previous chapters, these categorizations are influenced by the children's past experiences with a named disease, previous encounters with a medical professional, experiences of their peers and science lessons that they are taught in class. This resonates with the findings by Charman and Chandiramani (1995), Buchanan-Barrow et al. (2003), and Piko and Bak (2006). Another aspect of influence I suggest, through interactions with the children, is their context. The children referred to disease categories that are prevalent within their society such as malaria, diarrhoea and typhoid. What they know by virtue of being members of a particular society is brought to bear in the framing of their sensations of illness. In what follows, the focus is turned to the ways in which adults conceptualize and frame children's illness complaints.

8.3 Social obligations, problems in the home and lifestyle patterns: adult's unpacking of children's illness complaints

While children frame illness within biomedical dimensions, adults, in this case mothers and teachers, do not follow a clear-cut procedure, but combine a series of possible explanations for why a child is complaining about feeling unwell. These explanations, in their view, stem from stress related to social obligations that need to be met, problems in the home, lifestyle patterns and in rare instances a medical condition. In conversations with teachers and mothers, conceiving children's complaints within biomedical categories was the least likely dimension. Thus, it can be stated that adults view children's illness complaints as a multi-faceted phenomenon and in more psychosocial terms.

The social demands and obligations that adults expect children to participate in include attending school every day, taking part in household chores and attending Quran recitation school. With regards to this, both parents and teachers indicate that children use illness as an excuse when they are overwhelmed by these obligations:

My daughter is the same, always finding excuses when it comes to doing her share of the work in the house. She will come up with all types of sicknesses so that she won't work. But after the work is done then I have my peace of mind.

As for the other one [other daughter], she doesn't like mathematics so on days that they will be having maths she is usually quiet and sometimes she will tell me Mama my head is paining, I can't go to school today and all that. (Sumaya, mother of three).

A teacher, on the other hand, stated:

... I think she didn't like school. Because I'm told they did all sorts of scans and tests on her but they all proved negative and yet she was complaining of chest or is it heart pains and headaches. So some of the children, it's normal. They don't like school so they'll be using sickness as excuses. But it is a process they must follow, so what can you do? (Lucy, female teacher).

Regarding problems within the home, teachers mainly took this position to conceive children's complaints. In their view, the complaints children have about being unwell are manifestations of happenings within the home, and so when things are not going smoothly at home children react with illness claims:

There was a girl in class 5 or so. She was always sick. She was never well in school. It was either headache or stomach ache, but mostly stomach ache. Everyone was fed up with her and some teachers said she was lazy and others said she didn't like school... I went ahead to invite the father, because she lived with the father. After much discussions and probing, I found out that the girl's mother and father were divorced and so the father went to bring her from Kumasi [Southern Ghana] to live with him. It seems the girl had not adjusted to the situation and was also not used to the living conditions in the North...The father was also not always available so the grandmother takes care of her. She wasn't used to all these people. So her behaviour was just a reflection of the happenings at home. (Mary, female teacher).

Both mothers and teachers also explained children's illness in terms of the children's lifestyle patterns, include eating too many sweets, buying food from vendors instead of bringing packed lunch from home, watching too much television and not sleeping enough. However, on the part of teachers, this

explanation was resorted to while blaming parents for not adequately monitoring the children:

If it is headache too, I ask them if they had enough sleep the previous night. That is the time they went to bed and when they woke up. Some of them are just tired and all they need is rest. Sometimes you can talk to the parents to help these children rest adequately, it also helps. With all these telenovellas [Mexican and Spanish soap operas on most Ghanaian television networks] on TV these days some of them don't sleep early and so they wake up tired and they think they are sick. The parents too don't ensure that the children rest adequately. (Lucy, female teacher).

In the words of another teacher:

I ask them to go and eat especially when they complain of stomach ache. When they complain the first thing I ask them is whether they have eaten and if they have, what they have eaten. If they haven't eaten I ask them to go and eat. Those that are given money to bring to school, they spend these monies on all sorts of sweets and unwholesome food. See all the food they sell around here, sometimes you can't tell what sorts of spices or ingredients go into the preparation. That is why left with me alone I would advise parents to cook and pack lunch for the children that way they won't have to be worrying us with stomach pains here and there. (Florence, female teacher).

Mothers, on the other hand, blamed the packed schedule of the school system:

The school week makes them tired. They have to do a lot of things at a time, and they spend most of the day there. Also during the week day they don't get to sleep as much as they would want...so it is the tiredness that make them complain of feeling sick. During holidays you don't get all these complains. But they need it [school schedule] so that they can do a lot before the term ends. (Agnes, mother of four).

The stance of parents in considering a multi-faceted approach to conceptualizing children's illness complaints is in line with the findings of Mouratidi et al. (2015) that adults, unlike children, stress psychosocial dimensions in conceiving ill health. In explaining children's complaints in this way, parents and teachers resort to addressing the perceived cause of a child's stress as a remedy to the child's complaint:

If she is complaining like that I let her go and lie down and sleep so that she can rest. Also if it is headache, I ask her to drink plenty water. Water helps my headache so I let her use it too. It is not all the time that a headache needs paracetamol. Sometimes just resting is enough. (Ajara, mother of one)

Another mother exemplifies this:

When my daughter tells me she has headache I tell her to go and lie down and rest. Sometimes I let her turn off the TV and lie down and I let her know watching too much TV is making her have headaches. At times I ask her to drink plenty water, the headache will go. (Regina, mother of two).

Most teachers also resort to remedies within their scope to address a child's complaint of feeling unwell:

Usually when they come with stomach pains, I ask them to eat. Sometimes I may even buy food for the child to eat and after that they are fine. If it is headache too, I can let them lie on the desk to get at least an hour of sleep. That way they are refreshed and they continue the day normally. (Marilyn, female teacher).

Just like children, parents and teachers rely on their experiences in dealing with children to frame the children's illness complaints. Teachers for instance indicated that the length of years they have spent in the teaching profession allows them to know children and how they act. In their view, they have observed similar instances over time and the complaints don't usually end up as illness:

I have been a teacher for over eighteen years. I have been working with children all the time and I know how they behave and how they react to the things happening around them and so most times what they think is wrong with them is not actually what it is. So you as an adult will have to guide them and not give in to their every little complain. (Florence, female teacher).

For most parents and teachers, it can be said that the stance they take concerning a child's illness works for them over time. This stance is then reinforced and so ends up being their truth about why a child complains about feeling unwell. However, in some instances, parents and teachers consider a biomedical dimension to a child's complaint:

You know there was one time we had to call a child's mother to come pick her up. She was always complaining of one thing or the other. She complained that it was the same problem at home. But I told them to take her for a general check up at the hospital. There was probably more to the problem than we thought. (Anas, female teacher)

Another teacher indicated this:

For me often times when I have children who come to complain all the time I invite their parents over and insist on the parents taking them to hospital. You may never know. (Gertrude, female teacher).

On the part of parents, one mother intimates that:

When they [children] are given malaria treatment [by a pharmacist or doctor] not too long for instance and they keep worrying you with malaria symptoms even after the treatment then we have to consider treating the malaria again. In that case they need a stronger malaria drug. (Agnes, mother of four)

Further, parents look out for visible signs accompanying a child's complaint:

If she keeps complaining and depending on whether she has a high temperature, is vomiting and weak or maybe if it is her stomach and she has runny stools, then we go to the pharmacy or the hospital. (Regina, mother of two).

It is conceivable from the views of parents and teachers that medical aspects of a child's illness complaint are resorted to when there is persistence of the complaint over time or a child continues to complain of feeling unwell even after an encounter with a medical professional. Also, it stands out that when parents and teachers see visible signs and a child does not need to form words to describe their subjective feeling, they are more likely to conceive the child's state in biomedical terms. However, it appears that even when a biomedical dimension is resorted to, they are not quick to assign specific medical categories to these complaints like the children do. They instead suggest or make use of a formal health institution and health professional or use informal interactions with a health professional to ascertain the cause of a child's complaint:

Like I said we go to the pharmacy or I can call one of my nurse friends and they suggest what to do. (Sumaya, mother of three).

In terms of dealing with a child's complaint when medical dimensions are considered, another mother was of the opinion that:

If I can manage it in the house I do. Otherwise I take them to the hospital. I keep first aid at home so I give them that as well before going to hospital if it doesn't get better. Or I will go to my friend who has a pharmacy shop and describe to them what's wrong with the child and she will give me medicine. But if it is just headache and there is no temperature then I let her drink plenty water and rest and mostly she is fine. (Hajia, mother of three)

While treatment options are determined by how a child's claim of illness is framed, there are instances when treatment options are influenced by the parents' previous encounter with professional healthcare establishments:

For me I hardly do [take children to the hospital]. The hospital is usually too crowded. Sometime ago when I went to the doctor myself I sat at the hospital from 9 am till 5 pm. Wasted my whole day only to be prescribed paracetamol and some malaria drugs which I could have easily got from the pharmacy. So for me unless it's a matter of life and death I do not think I'll go and waste my time at the hospital again. Even picking your folder alone at the OPD [Outpatient Department] is serious. TTH [Tamale Teaching Hospital] is worse. These days you can easily do lab tests at some of the big pharmacies and it's faster. (Pagnaa, mother of three).

This was reiterated by another parent:

The health insurance has now made the hospital not attractive at all. Too many people. For me when I need to, I take them to the private hospital... It's far and I have to pay but it's faster. There is even this new hospital, Habana and I hear they are good but I haven't tried them yet. (Sumaya, mother of three).

While the views of parents presented here are mainly those from middle class backgrounds, children's narratives and accounts from the more lower class backgrounds do not show differences in the ways in which parents frame illness complaints. Differences however lie in the choices of parents when a formal health institution or health personnel is resorted to. While most of middle class parents viewed the health insurance as some kind of impediment to receiving rapid, high-quality healthcare, lower class parents, in the views of their children, ultimately resorted to it when there was the need to use a health professional. In conversations with these children, when parents opted for a hospital, it was usually synonymous with having a National Health Insurance (NHIS) card:

My mother take my health insurance card and we go to the hospital. In the hospital the doctor make us do some test and they check my temperature and then they say that I have to stay in the hospital because I am sick. (Ten-year-old Rubia).

An eleven-year-old boy also illustrated this:

My father take my card to the health insurance office because it has expired and they renew it. Because there are many people at the health insurance office we couldn't go to the hospital that day. So when he come to the house, the next day he pick me with the motorbike and we went to the hospital.

It is thus obvious that not only does the perceived cause of illness influence the nature and direction of health seeking, but also the resources available to do so (Fiereman and Jansen, 1992; Mechanic, 1992; Asenso-Okyere et al., 1994; Tipping and Segall, 1995). Discussions so far have centred on the varying ways in which children and adults conceive of illness and the treatments in line with this. These discussions have prioritized physical ailments and complaints surrounding the physical body. In interactions with parents, teachers and children, however, some aspects of children's psychological and mental state emerge. In the section that follows, I delve into these states and show ways in which they are made sense of.

8.4 The normalization of otherwise problematized mental and psychological states of children

The mental or psychological states discussed here refer to feelings of sadness, learning challenges and hyperactivity, which were the three recurring mental and psychological issues during interactions with children, parents and teachers. I use hyperactivity to refer to teachers and parents' description of children's activities as *'never sit at one place'*, *'all over the place'*, *'never concentrate'* and *'gidigidi'* which is a Ghanaian term describing someone who is overly active or too quick. Learning challenges is used to capture teachers' words of *'poor academic performance'*, *'not good academically'* *'not able to catch up with classmates'* and having a *'learning disability'*.

Sadness was mostly referred to by children, hyperactivity by parents and teachers, and learning challenges only by teachers. As already indicated in chapter five, children did not problematize sadness whenever it was encountered in interactions. This was mainly due to their inability to find words to describe exactly what it is. They were also unable to concretely locate it in their body:

What will you even say is wrong with you? If it is your head you can just say your head. Or maybe you can just tell your mother that you are feeling sad but if someone didn't do anything to you and you are sad you will not have a reason for your mother why you are sad. So I don't know even know what you will say. (Ten-year-old Cephas).

Further, their reliance on medicines to deal with illness did not fit in with sadness since they could not think of any medicine that can deal with it. In this way, it was considered a normal part of everyday life, needing little to no intervention:

You can go out and play with your friends or you can just sing and forget about it [sadness]. You can also just be there and it will go away because you cannot take any medicine because you won't even know what medicine to take. (Eleven-year-old Mwinnome).

Children have been shown to understand and to frame psychological states and experiences (Charman and Chandirami, 1995). In their study, children were able to identify and mention symptoms of depression as related to illness. In contrast, whereas the children in my study identified life events such as death, separation of parents and not having their way as resulting in sadness, they did not relate it to illness. This may be because they were not presented with a specific category describing a psychological state. The study sought to grasp children's experiences through their own words and understandings.

On the part of parents and teachers, hyperactivity came up in interactions. Although they did not report these as part of complaints that children have, they indicated that they observed this in some of the children:

For instance, I taught a boy last two years in class three. Rashad will never sit at one place. He will move from one classmate's table to the next. The moment you shout at him to sit he will settle down but by the time you turn to write on the board he is up again. It was as if there were pins on his seat and he was always excited. He was such a difficult child to deal with. He was a distraction to his classmates

and anytime there was noise or a fight, you were sure to find out Rashad started it. (Florence, female teacher).

Another teacher also makes similar observations:

Ahhh I had a girl like that too, Eunice. She was very intelligent in class but she will never concentrate and she will always be out of her seat and disturbing the others. You could even find her dancing on her table (other teachers laugh and acknowledge they remember her)... So I devised a plan for her. Anytime I was teaching or needed to explain something, I always did it quickly for her so that she will absorb it before her attention shifts to something else. (Lucy, female teacher).

Parents also described similar behavioural patterns in children:

My neighbour's son is like that. He is always all over the place. But I tell her it is normal...You see eh when you have children like that it's a lot of work. Everyday someone will come with a complaint that your child has done this or that even when it's not true all because it is your child who is usually all over the place. It is worrying. Even in school at the end of the term they will write in his report card that he needs to sit up and study more. (Agnes, mother of four).

It is apparent that the child's behaviour is considered a part of the process of growing up. There are however hints of worry about the implications of such a behaviour when it comes to social obligations as well as interactions with others. Although teachers and parents both admit that children who present signs of hyperactivity can be a worrying, they do not conceive such behaviour in biomedical terms. In their view, it is a stage every child, especially boys, will pass through:

Aaah right from when they are born, they breastfeed more, they cry more, any small pain they are crying. They are never calm. As for boys... No! No! No! No! They [boys] are a lot of work... Owwh it is their nature. When they get to a certain stage they stop. It is all part of their growing up. (Sumaya, mother of three).

Further, the opinion that such behaviour is what childhood actually constitutes is expressed:

You see when you think about children not sitting in one place, not paying attention and the like, you are actually talking about children [laughs]. That is them and they will grow out of it. In my twelve years as a teacher, I have seen it all. Some grow out of it and others just keep being children. I don't think it's a problem. You just need patience in dealing with such children. Because when you keep beating them, a time comes when the cane does not instil any fear in them. We intimidate them for nothing. They should be given room to be children. (Charles, male teacher).

Again, when a teacher was directly asked whether such behaviour by children is considered a health problem, the behaviour as constituting childhood was further emphasised:

Oh no. You see it's not everything that we think is out of the normal that should be considered a health issue. They are children and children are different. They are different in their upbringing, different in what they eat, and all sorts of things. They are just children and should be allowed to be as such. It is normal, some children are like that. (Mary, female teacher).

Besides viewing this as normal, some parents attributed it to certain medications that mothers take during pregnancy and food that the child eats:

I have heard that when you are pregnant and constantly taking para [paracetamol] and you give birth the child will be 'gidigidi' [overly active]. Or when you give the child too much sugar. It's always like they have taken alcohol. They'll be all over the place. One of the women staying in our compound has a boy like that. He is about my small [younger] daughter's age [between age 7 and 8]. So mostly she prays over him and anoint him with oil. But I tell her that as he grows he'll change. (Regina, mother of two).

I suggest here that it is not the actions of the child that are problematized, but rather the actions preceding the behaviour, mainly performed by the caregiver. The child may be seen to be absolved from any blame and so the behaviour is normalized. Although some of the speculations cited leading to this behaviour in children border on biomedicine (the use of paracetamol), the strategy resorted to is not in congruence with biomedicine. There is also a glimpse of spiritual connotations being made about such behaviour. It indeed manifests the assertion by Assimeng (1995) that when people are presented with difficult and unexplainable situations they resort to religion.

Besides hyperactivity, teachers also made references to learning challenges among children:

Well I think I have had challenges with some children who are not good academically. No matter what you do they just are not able to catch up with their classmates. (Ziblim, male teacher).

Another teacher reiterates this:

I have a girl like that in class two, about seven or eight years. Can you believe that as at class 2 she cannot still recognize the letters of the alphabets and the sounds as well? I try my best but it's just not working. This is someone who has passed through nursery, KG [kindergarten] and class one. I called the parents and informed them and told them to take her to the hospital for a check-up because it might be a sign of a bigger problem...maybe a learning disability or a behavioural disorder. (Florence, female teacher).

In this case, the learning challenges are problematized and teachers suggest seeing a medical professional. Parents however resist this label of a medical problem of their child's behaviour:

Oh the mother was pleading with me to take the girl through extra classes after school so that she could catch up. They were willing to pay for it. So I started with her but still. I even wrote the alphabets on cards for her to always carry around.

After a while she stopped staying back for the classes, the parents said nothing and I didn't confront them. (Florence, female teacher).

Further, the teachers not only indicate the stance of parents not recognising these things as problems but also acknowledge their limitations as teachers to deal with them:

You know some of the parents do not want to hear negative things about their children. After all who wants to be told their child has a problem. But if you don't draw their attention anyway it's the child who suffers. You can do your part but once it's not your child there is a limit to what you can do. (Marilyn, female teacher).

It appears that both children and adults mainly do not problematize children's psychological and mental states in relation to everyday practices. While children do not have the words to adequately capture emotional states, parents and teachers conceived these states as what childhood actually consists of. These findings can be related to observations in the Netherlands of low mood outside of the clinical realms, which indicates that everyday sense-making and concerns do not necessarily encourage medicalization, but rather people have a broad array of interpretations at their disposal to fall on (Bröer and Bessling, 2017). In addition, in a context where psychological and mental health issues are not largely prioritized, these states may more likely be normalized (Bird et al., 2011; Doku et al., 2011; Asamoah et al., 2014; Kyei et al., 2014). Teachers problematized learning challenges and seem to suggest medical interventions but parents resist these labels. This finding to some extent echoes the assertion that psychological states of children are problematized and medicalized within institutional contexts such as the school (Conrad, 1975; Rafalovich, 2005).

8.5 Conclusions

The key concluding observations embedded in the findings in this chapter are that children are more likely than adults to attach medical attributes, i.e. medicalize their bodily sensations. Framing their sensations in this way, children

rely on and expect adults to deal with their complaints with medicines. Adults medicalize children's complaints with caution because of the multi-faceted way in which they unpack these complaints. Parents and teachers consider a varied outlook to framing children's complaints. These include stress stemming from the need to meet social obligations, lifestyle patterns, problems at home, and in rare cases a medical condition. This outlook influences the treatment options adopted by adults who believe that addressing the source of a child's stress will ultimately end their complaint. This approach is reinforced by their success in the past in dealing with children's claims.

Largely, when parents and teachers consider a biomedical dimension to frame a child's complaint, they are not quick to attach medical categories. They are more likely to make use of the opinion of a health professional. Also, those who belong to the middle class have a myriad of options when resorting to a professional. The NHIS card however remains the main determinant of choices for those in the lower classes.

In addition, psychological and mental states such as sadness, hyperactivity and learning challenges have also been recognised by children, parents and teachers. These are however not problematized in relation to everyday needs. In the case of children, they do not have the words because they cannot conceptualize the emotional state of sadness in concrete terms. Parents and teachers also consider hyperactivity in children as actually constituting childhood, especially for boys. While teachers are more likely to medicalize learning challenges, parents resist such tags for their children.

In summary, this chapter enabled a glimpse into ways in which some form of medicalization takes place in a bottom-up approach: that is, from a powerless social group, non-professionals and in instances where a diagnostic label has not yet been given by a medical professional. It thus challenges the dominant top-down approach to medicalization. Further, it shows that even in a context where medicalization is less resorted to, needs and practices embedded in everyday interactions may be medicalized.

9

**An overview of the research and its
implications for research and practice**

9.1 Introduction

In this chapter, a summary of the thesis is made and the main findings with regards to the research questions are highlighted. The general conclusions of the study in relation to previous research cited and the theoretical and conceptual framework used are also detailed. In addition, the implications of the findings for research and practice, the limitations of the study and possible areas of future research with children within Ghana and similar contexts are outlined.

9.2 Overview of the study

The foundation of this study is that with the emergence of the new paradigm for the study of children, several studies have made the case for children's agency in their lived experiences. This has increasingly shaped child-related policies and practices including healthcare. It has led to the recognition of children's ability to make their own healthcare decisions (depending on their age). Further, it has been argued that the case of children's agency no longer needs to be established (Hutchby and Moran-Ellis, 1998). Rather, what it actually consists of, the forms it takes, the relational parameters within which it is enabled or constrained and the context within which it takes shape are the elements that continually need to be ascertained on an empirical level (Hutchby and Moran-Ellis, 1998; Mayall, 1998; Christiansen, 1998; Mayall, 2015). In this regard, empirical research has explored children's competence in their health and illness experiences within specific contexts, situations and child-adult relations. These show that children's active role in making sense of and dealing with illness is manifested in everyday situations and is part of ongoing interactions and negotiations with adults (Christensen, 1998; Mayall, 1998; Christensen, 1999; Brady, 2014; Jenkins, 2015; Martin, 2015; Reindstedt, 2015).

While focus has largely been on the Western context, studies have emerged in the non-Western context, specifically Africa, where policies surrounding child health and the cultural and social values around children differ markedly (Geissler et al., 2000; Geissler et al., 2001; van Reeuwijk, 2001; Akello, 2003; Onyango-Ouma et al., 2004; Wasike, 2007; Akello et al., 2007; Akello, 2010; van

Reeuwijk, 2010; Bernays et al., 2015). These studies show that even in such a context, children take active roles in dealing with their illness in terms of self-diagnosing and self-medicating of their illness experiences. However, these studies have taken place in a context of war, made use of named disease categories and have not particularly focused on children's social position such as social class in interactions surrounding illness. Meanwhile, Lareau (2002), for instance, indicates that the nature of child-adult interactions and the outcomes they produce for a child are to a significant extent influenced by social class.

The present study offers perspectives from an African country with a similar context to the above highlighted studies, specifically Ghana, where child-adult interactions are mainly perceived as strictly hierarchical. This is coupled with a healthcare system that prioritizes the needs of children below the age of five, and adolescents, leaving those in between these two categories—primary school children—without any specific health policy stipulations. In addition, there is a dearth of research considering children as social actors in their illness experiences and prioritizing their perspective in this setting. Meanwhile, possibilities have been shown through the work of NGOs and the media for children's participation in such a context. In this regard, I argue that social change and the rise of the middle class in the country have potentials to alter the existing sociocultural norms and values that surround children. I try to locate ways in which these may alter child-adult interactions in relation to illness.

The focus in this thesis was on children's illness complaints that have not yet been given diagnostic criteria. This was to enable an understanding of how competence is constituted in the illness experiences of children when there are no words to describe what the child is feeling in a context of limited participation and decision-making on the part of the child. Taking this stance presents a least likely situation, or what I described as a triple hurdle: the children's complaints are weak because they are subjective, what they are feeling has not been medically diagnosed by a professional, and there are no adequate structural policies that deal with the health needs of the children within this category for the children to make a case for feeling unwell and to take steps to remedy it.

To achieve the aim of this thesis, the following specific questions were asked:

1. How are perceived sensations of feeling unwell actively constructed and dealt with by children in everyday interactions?
2. How does a child's social position influence the construction of and the strategies to deal with these sensations?
3. What are the circumstances under which the genuineness of a child's claim of feeling unwell are resisted, modified or accepted by parents and teachers?
4. What and how are medical categories and treatments used by children and adults to frame a child's sensation of feeling unwell?

Focusing on everyday interactions in relation to illness, I drew on a number of theoretical concepts: agency (Prout and James, 1990), generation (Alanen and Mayall 2001; Mayall, 1998, 2015), health-seeking behavioural models in the context of a pluralistic healthcare system (Kleinman, 1980; Good, 1994; Asenso-Okyere et al., 1994; Tipping and Segall, 1995), and the medicalization theory (Szasz, 2007; Conrad, 2007; Parens, 2011). These theoretical concepts helped to situate the study, highlight aspects of the work and to aid the explanation of emerging issues from the analysis. These theoretical issues deal with agency, relations in interaction and illness behaviour.

Further, in addressing the research questions, I chose methods guided by the research orientation which consider children as active participants in their everyday lives, as capable, and as competent of making sense of their own lives (James, Jenks and Prout, 1998; James and James, 2004). Following this line of thought, I made use of qualitative research methods that give children a direct voice and privileged their experiences. An ethnography was made of two primary schools (BPS and SNPS) in the Sagnarigu municipality of the northern region of Ghana. One school was middle class and the other lower class, to allow for a comparison of child-adult relational patterns and their consequences for the dimensions and nature of children's competence in their illness situations. My experience as a child in both of these schools helped me reflect on and to

immerse myself in the everyday experiences of the children. The children who participated in the study were between the ages of seven and eleven years old.

To elicit data, I made use of a triangulation of participatory data collection techniques so that any shortfalls in one approach were overcome by the other approaches. These techniques were: observations, participant observations, classroom interactions with the children, essay writing, focus group discussions with the children, in-depth interviews with the children, focus group discussions with teachers, informal conversations with groups of parents and individual parents, and interviews with teachers in charge of health at both schools. These activities were either audio recorded and transcribed verbatim or hand written in a field notebook. Data analysis occurred at the same time as data collection as a way to ensure that the emerging data was clarified by the participants, as well as to inform the next steps of data collection. The analysis was done through extensive reading and rereading of field material, and emerging relationships and themes were identified and categorised. The dominant themes to emerge from this exercise shaped the chapter titles and sections presented and discussed in the findings.

From the analysis, four major themes emerged which address the research questions. The findings have thus been constituted within these main themes, namely: children's sense-making of feeling unwell; children's social position and the resources available to them to deal with feeling unwell; the circumstances under which a child's claim of feeling unwell are resisted, modified or accepted; and the different ways in which children and adults frame complaints of feeling unwell. In what follows, I present a brief summary of the main findings.

How are perceived sensations of feeling unwell actively constructed and dealt with by children in everyday interactions?

With regards to the first research question, it emerged that children come to know and make sense of their illness sensations through an exploration of their body, past experiences with illness categories and knowledge of their physical environment. In this way, the children's understandings and sense-making of their sensations of illness is related to their physical body. This is because for

them, the body is concrete, visible and easy to point to if they have to report what they are feeling to an adult. When what a child is feeling is not obvious to those they interact with (teachers, parents and peers), it becomes apparent for the child to put his or her feelings into words. Children then use words and expressions such as '*basaa*', '*my eyes are turning*', '*something is pounding inside my head*' and '*my head is paining*' which are common expressions within Ghanaian society to convey what they are feeling.

From sensations, children consider a combination of signs and their persistence over time in order to build a self-diagnosis and then decide to deal with them or seek help. In dealing with these sensations, children report to either parents or teachers, seek help from their peers or manage them themselves. Managing them involves self-diagnosis and self-medication by taking medicines stored at home or bought from chemists and pharmacy shops. The findings also show that the common health complaints that the children have include headaches, diarrhoea, stomach aches, typhoid, coughs, eye infections and chicken pox. These complaints all reflect the children's focus on more visible and concrete signs to make claims of feeling unwell.

How does a child's social position influence the construction of and the strategies to deal with these sensations?

The findings that reflect the children's social position and the resources available to them to deal with feeling unwell address the second research question. It emerges, based on the daily life and occupations of the parents of the children from the two schools studied, that they largely belong to different social classes. While children of BPS can be classified within the middle classes in Ghanaian society, those from SNPS can be considered within the lower classes. Social class is identified as a crucial influence in how teachers relate with and interact with children. That is, teachers' relations with the children are influenced by the power positions of the children's parents. While teachers at BPS engage in negotiations, dialogues and appeals with the children, teachers at SNPS issue directives. The result of these patterns of interactions and organisation of the children's lives is reflected in the ways in which children's claims of illness are dealt with.

Children of SNPS, whose times are not so scheduled as those at BPS, have more free time to engage with and to 'hang out' with their peers. They also engage in household chores including running errands such as buying medicines. They are thus equipped with the ability to buy medicines on their own when they feel unwell. Children of BPS, on the other hand, are able to persist and to take part in decision-making in their claims of illness with adults because of their interaction patterns. Their counterparts at SNPS are unable to persist in their claims, but to overcome this constraint they innovate by engaging in self-diagnosis and self-medication of their sensation of illness.

Besides social class, gender emerges as an influence on how children's competence in their illness claims is constituted in interactions with adults. This is largely due to the different expectations and views parents and teachers hold about boys and girls. While teachers hold an ambivalent position concerning girls' claim of illness, they are more straightforward in accepting boys' claims. This is because girls are perceived as fragile and at the same time considered to always make complaints about feeling unwell. Girls are also expected by their parents to take an active part in household chores as part of their social obligations. Thus, when girls complain of feeling unwell, it is interpreted by parents as a ploy to escape their duties. Boys however are perceived as tough and so parents and teachers do not always get complaints from them. Once a boy makes a complaint, his word is taken as true. Thus, boys' and girls' competences in their illness experiences are not constituted in the same way by adults.

In dealing with illness, children intentionally make use of and rely on social connections. They are more likely to rely on their mother or mother figure, their friends and family members with whom they are friendly when they feel unwell at home. In their view it is a matter of the availability of these people, the ease with which they can make a claim about feeling unwell and being friendly with these connections. In school, children rely on teachers with whom they are familiar, or teachers with which they share an ethnic background or go to church with. They and their parents nurture and foster these relations through gift-giving for the sake of the child.

What are the circumstances under which the genuineness of a child's claim of feeling unwell are resisted, modified or accepted by parents and teachers?

In addressing the third research question, the circumstances under which children's claims of feeling unwell are resisted, modified or accepted are identified. The findings indicate that children largely rely on their mothers or a mother figure when they feel unwell. This is due to their views about mothers as feeling their pain, showing empathy, being the ones responsible for taking care of the sick at home and their availability. Mothers on the other hand assume the responsibility for caring for their sick children because that is what society expects of them. They rate their mothering abilities on how well their children are and how others see their children. Further, mothers conceive mothering as a natural phenomenon and so this enables them to see the pain their children are going through and to make the right decisions about their claims of feeling unwell. Teachers also rely on their experiences as mothers to judge the genuineness of a child's claim of feeling unwell. Male teachers are likely to direct children who report feeling unwell to female teachers who have children. When a male teacher takes charge of children's claim of illness, he considers himself to be patient, caring and able to sacrifice his time, similar to what mothers are expected to do.

While children expect mothers to feel their pain, mothers assert that they see the pain. These differing outlooks become a source of tension between mothers and children when the former are ascertaining the genuineness of children's claim of illness. Mothers use the space in which a complaint is made, the need for a social obligation to be met, the child's past illness history and visible signs in relation to the personality of the child in either accepting, modifying or resisting a child's claim. Children who have an existing medical condition, have been admitted to hospital in the past, and have visible signs of illness usually stand a better chance of making a successful claim of illness. On the other hand, children who complain often or make a complaint when there is the need for a social obligation to be met are usually unsuccessful in their claims. Children counteract this by persisting in their claims.

What and how are medical categories and treatments used by children and adults to frame a child's sensation of feeling unwell?

In relation to the fourth research question, the ways in which children and adults frame complaints of feeling unwell, the findings show that children have an unvaried way of conceptualizing their illness. They largely rely on biomedical categories to frame their sensation of illness. They therefore resort to and expect adults to use medicines to deal with their illness. On the contrary, parents and teachers follow a multi-faceted approach in conceptualizing children's complaints. They consider stress from social obligations, problems in the home, lifestyle patterns and in rare instances a medical condition. With regards to behaviours and sensations that are regarded as mental and psychological disorders in globally available diagnostic practices, children do not problematize these. Parents and teachers in some instances though use psychological reasons such as stress within the home to postpone a child's claim of feeling unwell. On the whole, however, children and adults do not differ in the ways in which they frame these psychological and mental states. The psychological and mental states that emerged in the study include sadness, hyperactivity and learning challenges. While children did not have words to frame exactly what sadness is, parents and teachers considered hyperactivity in children to be what childhood actually consists of. Teachers problematized learning challenges and suggested medical interventions but parents resisted these labels.

9.3 Relating the findings to previous research

In this section I present the main findings of the study in relation to the key and relevant literature that guided the work. I detail the points of convergence as well as contradictions between the current work and the literature cited. Further, where necessary, I highlight contributions that my study makes to the body of work in this respect.

Research with a focus on children in Ghana and similar contexts often portrays child-adult relations as strictly hierarchical and relatively stable (Adu-Gyamfi, 2014; Boakye-Boaten, 2010; Twum-Danso, 2009; Salm and Falola, 2002; Kauda and Chacha, 1999). Findings from the study, however, show that child-adult

relations within this setting can be fluid, that they are influenced by social class i.e. the power position of the parents of the child, and that the relations between children and adults are gendered when it comes to illness (chapter 6). It is therefore justified to conclude that the ways and the extent to which a child's competence and participation is allowed especially within this context is dependent on the child's social position, i.e. social class and gender, rather than the 'stable' values that surround child-adult interactions.

Health research within Ghana has identified its health care system as pluralistic in nature (Senah, 2001; Twumasi, 2000; Senah, 1997). However, among the children interacted with in my study, this did not reflect in their health-seeking behaviour and the strategies they resorted to in dealing with feeling unwell. The finding challenges the pluralistic view of healthcare in Ghana. The children reported either being taken to hospital or self-medicating. Other avenues for seeking health such as the folk sector were not used by any of the children. While acknowledging that my sample was small and located within an urban area, this outcome may be explained by the children's conceptualization of illness as biomedical, and so they resort to biomedical remedies. However, what this points to, which is worthy of note, is that the healthcare system and its related practices may work differently for different members of society. That is, children's perceptions and practices differ from adults whose perspectives are mainly documented and represented in the health care literature on Ghana. The contribution my study makes, then, is to open up discussions and to provide evidence for the importance of engaging children directly in research. This will help produce relevant and nuanced data that is reflective of the society and aids meaningful policy interventions.

Taking into consideration the ways in which children make sense of and deal with their illness, my research finds that children display an awareness of their body which is usually the starting point for being in a state of feeling unwell. This finding confirms the position of researchers that an awareness of the body among children becomes some kind of tool for exhibiting competence (Mayall, 2015; Martin, 2015; Christensen, 1999). Within a non-Western context, physical signs and symptoms such as a headache, vomiting and stomach ache which

disrupt normal everyday routines have been noted as the basis for children's recognition of feeling unwell (Akello, 2010; Akello et al., 2007; Wasike, 2007). These observations are consistent with findings that are made in my study (chapter 5). This goes to emphasise the importance of the physical body to children in making sense of illness, as the body is concrete and can easily be seen. Thus, while what a child may be feeling in the body is not directly evident, this subjective feeling is assumed and acted upon by the child as a bodily phenomenon and not for instance a spiritual or unseen phenomenon. This renders the body accessible and the feeling logical to themselves and to others. Further, in questioning how children come to know about feeling unwell, the findings show that children rely on their peers, the media, lessons taught at school, their physical environment and previous illness experiences. The results on this aspect of my study are comparable with earlier works on how children come to know that they are unwell (Akello, 2010; Akello et al., 2007; Wasike, 2007; Christensen, 1999; Bluebond-Langner, 1978).

Concerning the resources children use to deal with illness, this study adds a dimension to the relevant literature available. Earlier studies show the importance of resources such as money, location and gender in dealing with illness (see Hampshire et al., 2011; Akello, 2010; Wasike, 2007; Geissler et al., 2000). While their findings suggest that these resources are necessary for children to deal with illness, my study shows how relations and interaction patterns between children and adults either foster or hinder the use of these resources to deal with illness. I introduced the concept of generation, which allowed an inclusion of the social position of the child (social class and gender) in determining the kinds of resources it allows or hinders for children to deal with feeling ill (chapter 6). This evidence is supported by Christensen (1998), who suggests that children are treated based on how they are seen and interacted with. Still on relations, I further point out that children are intentional in choosing social connections that make it easier for them to make a claim about being unwell and to get the desired help.

In relation to the circumstances under which a child's claim of feeling unwell is resisted, modified or accepted, I present similar findings and make a new

contribution. The role of the mother in this process is emphasised in the literature (Prout, 1986, 1988; Mayall, 1993, 1998). This is comparable with my findings, where children are constantly engaged with mothers or a mother figure in their negotiations of feeling unwell. However, the reasons for relying on a mother figure go beyond the division of labour between men and women in the household that other researchers have noted (Mayall 1998, 1993; Prout, 1988). I add that the attributes of women specifically to 'feel' pain, as illustrated in chapter 7, is an important driving force for children to look to mothers when they do not feel well. In addition, earlier research presents the views of mothers about themselves in doing health care work at home (Prout, 1988). My study presents children's perspectives on mothers in this regard and shows that it is the way they conceive mothers that result in their reliance on them when they are unwell.

The results from my study which highlight the unvaried ways in which children conceptualise illness corroborates research showing that children mainly frame illness within biomedical terms compared with adults (see for instance Campbell, 1975; Springer and Ruckel, 1992; Charman and Chandiramani, 1995; Schmidt and Frohling, 1999; Van Reeuwik, 2001; Buchanan-Barrow et al., 2003; Piko and Bak, 2006; Mouratidi et al., 2015). In addition, these researchers observe that children's conception of illness is based on past experiences with disease categories or trivial infections and knowledge of biomedical health concepts (Charman and Chandiramani, 1995; Buchanan-Barrow et al., 2003; Piko and Bak, 2006). My contribution in this regard is that children do not just refer to any biomedical health concept, but those disease concepts and categorizations that are prevalent and known in their context. That is, they are likely to project knowledge about their physical and social environment in relation to diseases in making sense of feeling unwell. Children also rely on their past encounters with a medical professional when attaching meanings to their sensation of feeling unwell. It appears then that the authority of doctors, in diagnosing a child's ailment in the past, supersedes that of parents and teachers. That is, while children may make reference to a past experience with a disease category to explain their illness, it is not just any kind of disease category they make use of, but one previously given by a doctor.

9.4 Reflections on the findings in relation to the theoretical concepts adopted

9.4.1 Child agency

Relying on the position that children are social actors and thus worthy of study in their own right in childhood research, I adopted the concept of child agency (Prout, 1988; Prout and James, 1997; Alderson, 1995; James et al., 1998; Prout, 2001; Prout, 2005). In addition it has been indicated that focus in research should no longer be about whether children exert agency or not, but rather attention should be paid to ways this agency is manifested, the dimensions it takes and what it actually consist of. Following this, I placed emphasis on how children's agency is constituted in their illness experiences.

The findings show that the children have several strategies to deal with not feeling well. In the first place, they are able to frame and to tell when they feel sensations of ill health based on the symptoms. They do this by relying on nonspecific feelings such as '*feeling some way*', specific feelings like '*pain in the body*', a particular feeling in a specific part of the body like '*headache*', and visible signs like '*vomiting*'. In this way, they display a subjective awareness of their bodies and note when there is a disruption to them. While this process of self-awareness is subjective, it accounts for the beginning of the process of considering a feeling within the body as a sign of illness or not. In that moment of feeling unwell, this feeling in the body precedes all the other influencers such as peers, parents, teachers, and the media in claiming the position of being ill. This awareness therefore forms their initial step to take action, which is an awareness of the body and its functions in dealing with feeling unwell.

Once the children acknowledge that they do not feel well, they are able to assign a disease category to their symptoms or to self-diagnose based on the severity of their symptoms. These include prevalent disease categories such as malaria in their environment, past experiences with a particular disease category, and interactions with their peers, teachers and parents. They thus make use of knowledge acquired in both their physical and social environments to construct and to name their sensation of illness. Findings from the study show

a consistent trend in the ways in which the children attach meanings to their sensation of feeling unwell. They rely solely on biomedical disease categories to frame their sensations. It is also evident that while the children mainly engage in medicalization, parents and teachers demedicalize or resist the biomedical labels that children resort to. This leads to tensions and negotiations between children and adults to come to an acceptable or modified frame for what the child is feeling. It is within these tensions and negotiations that children's active participation in their illness experience can be observed. While parents and teachers resist children's framing of their subjective experiences, the children find ways to navigate this. They either innovate, for instance by self-medicating, or persist in their claims until they are accepted (chapter 7).

Beyond diagnosis, the children's competence is also constituted in taking steps to deal with feeling unwell. This involves them intentionally and strategically seeking help from their social connections who they can easily convince or make a case of feeling unwell to. In other instances, they self-medicate. The weak policies surrounding pharmaceuticals in their context enables and makes this approach work. This sheds light on how specific contexts and situations may enable or hinder children's competence in their illness experiences. These findings are compelling as they show that, even in circumstances where children's influence is minimal, they are able to find remedies for their illness.

The results of the study support the proponents of child agency as they reiterate the stance that agency in children no longer needs to be established. Instead, dimensions of this agency within specific contexts, and how these contexts influence agency, should be the focus. What these findings lay out is that the specific context of these children equips them with particular knowledge and skills to deal with interruptions in their everyday routines. The weak policies surrounding pharmaceuticals, for instance, allow children to purchase and use medicines without restrictions. It also allows the advertisement of medicines on various media platforms including television and radio, and so informs children about the various medicines available for treating different ailments. The cultural phenomenon of sending children on errands also allows children to acquire the skills of buying different kinds of medicines without being questioned.

It stands out then that children's agency and the competence this affords is largely shaped by sociocultural settings. That is, there is some kind of context-specific agency. What this study shows is that, in making sense of the social world of children, the social, political and cultural milieu within which they live should be the starting point of analysis. This will aid a comprehensive understanding of the mundane experiences of children.

9.4.2 Generation

While presenting ways in which children's agency is constituted within a specific context, I also take cognisance of the fact that children do not act in a vacuum, but rather their actions and the parameters of these actions are shaped by their relations and interactions with adults. In this regard the concept of generation was resorted to, to allow an inclusion of the larger social structure in children's experiences. This enabled an understanding of how children's social life is structured and regulated as well as the social conditions within which their lived experiences are embedded.

Alanen and Mayall (2001) assert that individual children and adults interrelate across age divisions, power inequalities, and household norms and needs. Again, relationships are constituted between the social group of children and the social group of adults and interactions are across generations with different interests and needs all shaped by social norms and policies. Also, adults belong to a different generation from children and carry with them knowledge, assumptions and experience that they have acquired over their lifetime and influenced by the social forces in place in their lifespan (Alanen and Mayall, 2001). In this regard I make four contributory remarks to the theoretical concept.

In the first place, I identify social class as a crucial indicator of the patterns of interactions surrounding illness between the social group of children and adults. Whereas teachers engaged in negotiations and dialogue with middle class children, directives are issued to lower class children. I therefore argue that relations are not just between the social group of children and that of adults but further between the social group of children belonging to a particular social class and the social group of adults below that social class. That is, child-adult

interactions and relations are shaped by the power position of the parents of those children. Closely related to this, interaction patterns between adults and children are reflected in how adults react to children's claims of feeling unwell. These patterns either enable or constrain a child's ability to exert influence on their illness experience. While children may seem constrained in their ability to exert influence on their illness situation, it provides an opportunity for them to innovate. For instance, lower class children in the study who seemed to be restrained in persisting in their claims of feeling unwell either relied on adults who did not question their competence or resorted to self-diagnosis and self-medication.

Further, relations between adults and children are gendered. That is, parents and teachers interact with children based on their perceptions and expectations surrounding a particular gender. While boys are socialized to be *'tough'*, girls are considered *'fragile'*. Viewing them in this way plays a role in their ability to influence decision-making with regards to their illness.

The social norms of the home and the larger society also shape interactions. This places mothers in the lead role in dealing with children's illness whether at home or in school. However, as they belong to different social groups, mothers and children have interests and needs that contrast, which often leads to conflicts, as Whyte et al. (2008) have argued. In this way mothers and children clash over the genuineness of a child's claim leading to mothers rejecting, modifying or accepting the claim.

In addition, based on the main outlines of generation, mothers belong to a different generation to children and carry with them knowledge, assumptions and experience that they have acquired over their lifetime and influenced by the social forces in place in their lifespan. However, from the findings, I add that within certain experiences, such as a child with an existing medical condition, these assumptions, knowledge and experiences are suspended by mothers, who instead allow the child's (in)experience to take precedence. This shows that a certain status of the child enables or creates leeway to exert competence and leads to a recognition of this competence by adults in child-adult interactions.

9.4.3 Healthcare-seeking behavioural models in the context of a pluralistic healthcare system

Studying the illness experiences of children within a pluralistic and emergent healthcare system require healthcare-seeking behaviour models that take cognisance of this context. These models are however largely adult-centred. Kleinman (1980) identifies three often overlapping sectors of healthcare: the popular sector, the professional sector and the folk sector. The study finds that the actions of children to deal with their sensations of illness largely fall within the popular sector, i.e. therapeutic actions that people utilize without relying on any healers, either in the professional or folk sector. This usually takes place at home where illnesses are defined and healthcare initiated, and it involves self-medication, self-treatment and advice given by friends, relatives and work colleagues (Kleinman, 1980). I include the school as an arena for children to define illnesses and initiate healthcare.

The professional sector is synonymous with biomedicine, and the folk sector involves secular or sacred healers with no formal training (Kleinman, 1980; Hampshire et al., 2011). No child in this study indicated using a health facility alone. This reiterates the assertion made in the study that healthcare within this context is largely adult-centred. Unexpectedly in a context of pluralistic healthcare, no child mentioned using the folk sector either by themselves or in the company of adults. This could be in part due to the children's conceptualization of their illness as mainly biomedical and so needing biomedical remedies such as pharmaceuticals. In this way, health-seeking may be a more complex process than is often illustrated, comprising several decision-making processes and choices (Mechanic, 1992; Asenso-Otchere et al., 1994; Tipping and Segall, 1995; Senah, 1997).

The findings indicate that children display similar patterns of health-seeking to adults: recognition of and significance attached to the symptoms, perceived seriousness of the illness, the persistence of the illness, the perceived cause, knowledge of illness remedies and faith in the efficacy of the medicine available (Fiereman and Jansen, 1992; Mechanic, 1992; Asenso-Okyere et al. 1994; Tipping and Segall, 1995).

9.4.4 Medicalization theory

As the study focused on undiagnosed sensations of feeling unwell, I drew on the medicalization theory to show whether and how medical categories are used to frame children's illness complaints. Medicalization refers to the social process by which formerly non-medical problems become defined and treated as medical problems. Its dominant approach has been to focus on 'powerful adults': medical professionals, policy-makers, and pharmaceutical outlets (Szasz, 2007; Conrad, 2007). Where lay people's perspective has been considered it has largely centred on activists influencing medical practices, knowledge of diseases passed on through social networks and patients influencing the ways in which doctors should interpret their symptoms (Brown et al., 2004; Edwards et al., 2014; Liu et al., 2010). Focusing on a context where medicalization is less pronounced and on a minority group of lay people, children, I addressed the ways in which medicalization takes root (or not) in everyday practices. In terms of psychological and mental states, the study shows that children generally do not problematize these experiences. Although parents and teachers do not seem to medicalize psychological states, they can be seen to use it as a way to make sense of a child's claim of illness. Regarding learning challenges, however, teachers clearly suggest medical terms and treatments but parents resist these. While at the macro level, which is the institution of the school, children's behaviour is problematized and labelled, parents at the micro level resist such labelling and normalize the children's behaviour. On the whole, among young Ghanaian children, medicalization around psychological and mental states appears less pronounced than in Western societies.

The findings of the study further show that children largely make sense of and frame their physical sensations of feeling unwell with medical categories and so resort to medicines to restore health. On the other hand adults (parents and teachers) rarely resort to medical labels. Rather they engage in a varied approach to make sense of children's illness complaints. It stands out then that children are more likely to medicalize their everyday experiences and to seek biomedical remedies for those experiences.

This contrasts the dominant, top-down orientation of medicalization theory, which sees medicalization as the preserve of medical professionals, policy-makers, and pharmaceutical outlets that then 'trickles down' to lay people. The study shows that to some extent medicalization is rooted in everyday practices and needs and advanced by the seemingly most powerless: young children. This finding among a powerless group of people (children) who have not received a diagnostic label from a medical professional proves useful in strengthening the bottom-up approach to the medicalization theory. It also shows, even if in subtle ways, that in a context where medicalization is less pronounced, there are avenues for everyday needs and troubles to be translated into medical terms and treated with medical remedies (Conrad and Schneider, 1980; Emerson and Messinger, 1977).

To further the discussion of medicalization of everyday life, it becomes necessary to revisit the questions posed in the introductory chapter of this thesis in relation to medicalization. Regarding the relevance of medicalization outside of the clinical realm, it emerges from the study that it is mainly resorted to by children to frame their sensations of feeling unwell. For them, the use of biomedical terms and categories become concrete ways of making sense of the disruptions in their daily lives and dealing with them. On the other hand these biomedical categorizations are either dismissed or contested by their parents and teachers. These contestations lead to conflicts in interactions and relations because while daily disruptions trigger medicalization in children, parents and teachers offer a range of social explanations instead. While it functions as a sense-making tool for children, parents and teachers see it as a reflection of social crises especially at home or an excuse the child uses to shirk social responsibilities.

The role of the prevailing social institutions and biomedical establishments cannot be ignored in this process. For instance, as stated in the introduction to this thesis, the School Health Education Program (SHEP) in Ghana requires that subjects related to health and wellbeing are included in the school curriculum. Children are therefore taught about personal hygiene, food hygiene, water-borne diseases and environmental sanitation in school (Adu-Mireku, 2003). It is likely

that the children's knowledge of these subject areas are brought to bear in their conceptualization of illness. As indicated above, pharmaceutical companies capitalise on the poor regulations by government institutions to advertise on both television and radio using symptoms of various ailments which children are likely to draw upon in framing their sensations of feeling unwell. These structural arrangements may explain why medicalization dominates children's conceptualization of their illness.

In terms of the role of the dominant medical knowledge and discourses, it emerges that the main disease categories that children rely on are malaria, diarrhoea and typhoid, which are often the common diagnoses given at health facilities in Ghana. This was also evidenced in the children's responses as they pointed out that these are diagnoses they have received before from health professionals. The framing of their illness is therefore more in tune with generalised knowledge about illness rather than a specific knowledge about illness that reflects the medical knowledge or discourses available in their context. These discourses can be said to greatly shape the children's ideas about their illness. It appears then that doctors and medicines seem to have gained authority over the children's ideas about illness and this contests parents' and teachers' authority. While the children rely on this knowledge, parents and teachers contest and often resist it. It therefore emerges that parents and teachers, whose views represent dominant discourses around social life including healthcare, are in contrast with children's views. While my sample of parents and teachers is small and their views may therefore not be generalizable to all Ghanaian adults, these findings are compelling in relation to medicalization as they become pointers to further research and reflection around medicalization, particularly in Ghana. The questions of what exactly the dominant discourses around illness are, when they are resorted to as well as why and to what extent these discourses vary in shaping the conceptualisation of illness among adults and children can be looked into using a larger and more diverse sample.

9.5 Implications of the findings for research and practice

The study has some implications for research undertaken within medical sociology, medical anthropology, and childhood studies. In the first place, it contributes to the growing body of research that prioritizes children's perspectives in their lived experiences, specifically illness experiences in a non-Western context. The current literature, particularly on Ghana, shows that children's direct engagement in health research is almost non-existent and so this study provides a lens through which similar research could be carried out in the future. The findings from the study also highlight the changing dynamics of child-adult relations and the values surrounding children in Ghana. It therefore opens up further discourses surrounding children and the socio-cultural implications for everyday life.

The study has focused on children as social actors in their illness experiences in a context of weak healthcare policies and child-adult relations that are perceived as strictly hierarchical. It has shown the nature and patterns of interactions in children's illness experiences and the dimensions of competence it allows or curtails. While engaged in this endeavour, the ethical issues surrounding the study design and measures to mitigate or minimize them have been outlined. These could prove useful as a reference point for other researchers who are interested in engaging children directly in research within the Ghanaian or similar contexts. In addition, the research methods that have been engaged to elicit data may prove useful for research that seeks to involve children directly as participants.

Besides research, the outcome of my study has implications for practice. My findings for instance show that children are active rather than passive in making sense of and dealing with illness. For example, they self-diagnose and self-medicate, and mainly conceive of illness in biomedical terms. They are therefore drawn to remedies like pharmaceuticals to deal with feeling unwell. In this way, children should no longer be considered passive recipients of care but rather as active seekers of cure, in most cases on their own. There are thus implications for public health. There is the potential for drug abuse and drug

resistance over time. It is therefore critical for adults who shape policy related to children not to underrate children's potential. School health can begin to include the dangers of medicine use without prior consultation with a professional as part of behavioural change programmes that already exist in the School Health Education Programme (SHEP) for sanitation and hygiene. After all it has also been shown in this study that children make meaning through knowledge acquired from the classroom and interactions with peers. These avenues can serve as tools to reshape children's perceptions and use of medicines.

In addition, both of the schools did not seem to have a comprehensive and laid down procedure for dealing with children complaining about feeling ill. While the schools acknowledge that they are not health professionals, they are most often the children's first point of call. The Ghana Education Service (GES) may consider training school teachers in basic first aid and first response protocols as a way to enhance their capacity to interact appropriately with children feeling unwell, and to assist them when needed. In partnership with the Ministry of Health (MOH), the GES may also consider linking schools with child-friendly professionals within the established health facilities in their vicinities. These could also serve as first aid points for schools and allow medical professionals to deal directly with children feeling ill when necessary.

9.6 Limitations of the study

The study specifically focussed on children's illness experiences at home and school. While the home is included, first-hand observations of children's lived experiences within this setting were not done. Findings from the study that reflect interaction patterns and actions taken at home are based on children's accounts and retrospective narratives of these occurrences.

Also, while the study compared relational patterns on the basis of social class, only parents who fit into the middle class criteria were interacted with. Hence the views of parents within the lower class criteria are only taken from the descriptions, recounts and views of their children.

In addition, the study is a qualitative study of only two schools located in an urban setting. As a result of this small sample size, the findings of the study may not be generalised and the results may not be a reflection of the lived experiences of all Ghanaian children.

Overall, however, using triangulated data collection techniques have provided results that prove useful to aid an understanding of children as social actors in their illness experiences, in a context of child-adult relations that are perceived as strictly hierarchical.

9.7 Recommendations for future research

Given the limitations identified, suggestions are made for future research. Research on children's perspective in their illness experiences can be undertaken in a rural setting within this context to grasp the local expressions and meaning-making children engage in for feeling unwell and how patterns of relations play out and influence this process.

One key issue that emerged from the study is the different ways in which children and adults frame illness. While children mainly medicalized their sensations of feeling unwell, adults were more varied in their explanations. Research that specifically focuses on children's socialization around illness would be useful. This could answer questions such as whether, in the near future, Ghanaian society will be a largely medicalizing one, and the implications of this. It could also aid an explanation of why children's and adults' outlooks on illness differ.

Further, research that focuses specifically on the home and observes patterns of interactions between children and parents of different social classes at first hand is relevant. This will allow an insight into ways patterns of relations between parents and children in this context influence the nature and dimensions of children's competence in dealing with illness at home.

In addition, the study draws on children's complaints about feeling unwell in instances where a medical diagnosis has not been given or they have not

encountered a medical professional. For future research, it would be interesting to explore children's encounters with health professionals. This would make it possible for the nature of relations and patterns of interactions with children that exist in this context and their implications to be observed within the medical encounters.

9.8 Concluding Remarks

The study sought to interrogate how children in a context of an adult-centred, pluralistic and emergent healthcare system negotiate their illness experience at home and school. It highlights the ways in which children make sense of feeling unwell and take steps to seek health. It stands out that the children's competences are constituted within patterns of interactions that their context allows to deal with illness. Overall, the study gives insight into children's worldview concerning illness in a context in which their participation in decision-making is often perceived as minimal or non-existent.

Evidence from the study shows that children are not passive members of society in their illness experiences. Even in subtle ways, children have an influence on their own lives. They intentionally and strategically engage adults in interactions, and where necessary devise ways to deal with their illness. What this lays bare is that children should be interacted with as people with valuable insights and experiences, which can inform ways of thinking about policy interventions for them. The study and its findings further emphasise that the only way to better understand and interpret the world of children is to directly involve them in research and to treat their words and ideas as valuable and worthy of contributing to scientific knowledge.

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Appendices

Appendix 1: Informed Consent Form for Parents Explanatory Statement

Project Title: Children’s Matters: Negotiating Illness in Everyday Interactions at Home and School in Ghana

My name is **Colette Santah**, a PhD student of University of Milan, Italy and University of Amsterdam, Netherlands. I am a former student of the Shea Nut Primary School (Between 1992 and 1997)/ Baobab Primary School (Between 1997 and 2001). I am conducting a research to explore how children deal with feeling unwell when they are at home or school, who they report this to and what is done by teachers and parents for them. This project is towards a PhD in Sociology under the supervision of Dr. Roberta Bosisio (University of Turin), Dr. Christian Broer and Prof. Dr. Ria Reis of the Amsterdam Institute for Social Science Research (AISSR, University of Amsterdam, Netherlands). Findings from the research will make up a thesis and some of the results published in international academic journals.

The project targets primary school children, their parents and their teachers. Children will be engaged in group discussions and individual interviews. Permission is thus needed from you to engage you and your child (children) in this research. The interviews to be conducted will last between thirty minutes to one hour and conducted at a time and place that is convenient to all the participants involved. With your permission I will like to audio-record interviews but if you prefer I will take notes instead. Participation is completely voluntary and you or your child can decline to participate at any point during the research. Your privacy will be respected and any information you or your children provide will be treated with confidentiality. Recordings and hard copies of interviews will only be used for academic purposes. When findings from the research are reported it is assured that individual participants and schools will not be identifiable in such reports. This will be ensured through the use of made-up names (pseudo names).

For more information, concerns and questions, please feel to contact me on **0243667406, 0203877769, sancolette@yahoo.com**

Consent

Iconsent that my son/daughter
..... participate in the above stated research.

Signature **Date**

Appendix 2: Checklist for observations in the two schools

Physical environment of the school: - School building - classroom layout - Number of children in each class - Infrastructure and amenities available - The children's daily appearance - School schedule - How is the school space shared between teachers and children?	Observations	Date/Time/Place	Differences between the schools to note
Playground/break time interactions - What do the children spend this time doing? - How do the children relate to each other at this time? - How are the children relating to teachers at this time? - What kind of activities are the children engaged in at this time? - What type of activities are teachers engaged in at this time? - Any there any injuries while playing and what is done?			
Music and Dance Class - How are the children relating to each other? - How do the children relate to this particular teacher? - Are all the children engaged in the activity been performed? - What are those not engaged in the activity doing/ what is their demeanor/ appearance?			
Classroom and general interactions at school - Sitting arrangements - tone of the teacher on average to the pupils - How are questions asked and answered by both teachers and children? - the demeanour of the children when the teacher is in class versus when the teacher is out of the class - How do the children relate to each other in class? - The school assembly			
Children's interaction with parents at close of day - Which parents are picking up children - What is the means of transport used? - Children meeting with parents: what is their demeanour?			

Appendix 3: Guide for focus group discussions and classroom interactions with children

Before we begin, let's remind ourselves of some things:

In this discussion feel free to answer any questions that I ask.

You do not have to answer any questions if you don't want to.

At any time when we are conversing and you no longer feel like talking to the rest of us you can leave okay? I won't be angry with you and I won't use the cane on you for leaving.

If we are talking about something and you want to also talk but you are shy of your friends, you can wait when we finish you come and whisper it to me okay?

I accept all answers that you have. No answer is correct or wrong so don't worry, just tell me whatever you think okay?

We are all talking to each other so kindly do not laugh at your friends or make fun of them when they talk.

When you talk, you also allow your friend to finish talking before you talk again if you want.

What are some of the things you will like us to add to remind ourselves during the discussion?

1. What does it mean when someone says they are unwell?
2. Have you ever been unwell?
3. How did you know you were unwell?
4. Let us list some of the feelings you would consider as feelings of unwell.
5. What did you call what you were feeling?

6. What are some of the common illness (sickness) that you have ever had from two weeks ago to one month ago?
7. How did you know that it was that particular 'sickness' you had?
8. Did you tell anyone? If yes who and the reason? If no, do you have a reason for not telling?
9. If you were unwell in school, who will you tell? Can you give reasons for your answer or choice?
10. If you were unwell at home, who will you tell? Can you give reasons for your answer?
11. What are some of the things you felt that made you think you were unwell?
12. Can you remember a time you were unwell? If yes, when was this and can you describe how it felt like for you?
13. What do you do when you feel unwell?

Appendix 4: In-depth interview guide for children

I am going to ask you some questions about feeling unwell. It is almost like the discussions and talks we have been having in the classroom and also with some of your friends. When I ask a question you can tell me all you know about it okay? Like I told you and your classmates already with me there is no correct or wrong answer. Feel free and talk to me. If we are talking and you no longer want to talk to me you can tell me and stop okay. I won't be angry with you. If you don't understand my question you can tell me so that I can help you to understand or ask you a different question. The forms your parents signed, they agreed that I can use a tape recorder to record our conversation but if you don't want me to record it, you can tell me so that I don't record it okay. So relax, feel free and let's chat.

1. What is your name and how old are you?
2. Which part of Tamale do you live?
3. Who do you live with?
4. How do you come to school every day?
5. Can you tell me what you usually do when you wake up in the morning before coming to school?
6. Will you like to describe to me a day in your life/ Can you describe to me what you do in a day? (In instances of misunderstanding, further explanation is given).
7. What does it mean to you to feel unwell
8. Have you ever felt unwell? If yes, what was wrong with you? If no, do you know anyone who has been unwell? If yes, can you describe to me what was wrong with the person?
9. How did you feel and what did you call what you were feeling?
10. How did you decide the name of what you were feeling?
11. When you feel unwell who do you tell when you are
 - i. Home
 - ii. At school
12. Will you like to tell me why you tell the person you choose to tell?

Appendix 5: FGD guide for teachers

1. Length of time teaching at present school and being a teacher overall.
2. How will you describe the children you teach?
3. How will you describe the nature of the relationship between you and the children?
4. Do you have children complaining to you about not feeling well?
5. What do you consider as not feeling well among children?
6. What are some of the complaints that children come with?
7. What do you do for them when they report?
8. Do you always believe them when they report to you?
9. How do you decide to believe the child or not when they report?
10. What does the school oblige you to do when a child reports not feeling well?

Summary

Summary

This thesis is shaped by a change in notion from children as passive and incompetent beings in healthcare decisions to a recognition of their ability to make these decisions. These developments result from an increasing focus of social science research on children as active participants in social life. While research in this regard has increased over the years, the call has been for researchers to move from trying to establish whether children are competent in taking active part in social life to focusing on how competence is constituted in child-adult relations, within specific contexts. Competence then is to be looked at as ways in which children engage with their social environment as well as something they negotiate, argue about and struggle over in interactive encounters with other societal members within specific contexts and situations, rather than as a cognitive ability or a linear developmental stage in the life of children.

Researchers have followed this line of thought to situate research including health research within children's everyday lived experiences. These studies have shown that there is variation in how children's competence is constituted: it is an ongoing process in interactions and it is evident in everyday situations. However, to a large extent, these researches have been done in Western societies. Within non-Western contexts, specifically African contexts, health research focusing on children's perspectives has shown that children devise ways to deal with their illness that differ from those reported in Western societies, notably by resorting to self-diagnoses and self-medication. While these studies prove useful to understanding children's lives within these settings, there are limitations identified which make the scope and focus of my study worthwhile.

In the first place, one of the studies that provides essential literature on children's agency in their illness circumstances was carried out in a context of war. This makes the society disrupted and the circumstances of the children dire. Others have focused on existing disease categories such as fever, malaria and diarrhoea that are common within children's settings. In this way, the children are presented with an illness that is already named and then their understandings of this illness

are sought. In addition, while all of these studies take into consideration the relations and interactions between children and adults in the illness experience of children, their specific focus has not been on the social position of the child, such as social class, in interrogating the role children play in dealing with their illness by themselves. Yet studies have shown that the social position of children plays a crucial role in shaping the relations children have with adults, with consequences for the extent to which children are allowed to take part in decision-making concerning their life.

Departing from the majority of these studies, this study is set in Ghana where hardly any health research has been done that has directly sought the views of children on their illness experiences. Child-adult relations in this setting are mainly perceived as strictly hierarchical with little or no room for children to take part in decision-making. The healthcare system is also recognised as pluralistic with healthcare policy prioritizing the health needs of children below the age of five years and adolescents. However those above the age of five, and yet below the age of adolescence, mostly found in primary school, seem to have no health policy directly targeting them as they are believed to be a healthy group. As a result of these societal values and health policy around children in Ghana, they are not considered health seekers on their own but rather through the assistance of adults. Furthermore, this study moves away from existing disease categories to focus on children's complaints of not feeling well that have not yet been presented to a medical professional and so a medical diagnosis has not been received. This is to enable an exploration of the ways in which children in a society who are less likely to influence decision-making make sense of and negotiate their illness experiences in everyday interactions at home and school.

The study specifically asked four research questions: **a)** How are perceived sensations of feeling unwell actively constructed and dealt with by children in everyday interactions? **b)** How does a child's social position influence the construction of and the strategies to deal with these sensations? **c)** What are the circumstances under which the genuineness of a child's claim of feeling unwell are resisted, modified or accepted by parents and teachers? **d)** What and how are medical categories and treatments used by children and adults to

frame children's sensations of feeling unwell? I relied on a number of theoretical concepts including agency, generation, health-seeking behavioural models and medicalization as analytical tools to help delineate the study, operationalise my research questions and explain aspects of the study as they emerged from the analysis.

To answer the research questions, an ethnography was done among children aged seven to eleven years old in two primary schools in the Sagnarigu municipality in the northern part of Ghana. The two schools were chosen because of their difference: one was middle class and the other was lower class. This allowed a comparison of the interaction patterns between children and adults and their relevance in dealing with illness. The second criterion was based on my personal experience as a child in these two schools as a way to allow me to fully immerse in and to grasp the experiences of the children. The research methods and techniques used were guided by the research orientation that views children as active participants in their everyday life and capable of providing in-depth insights into their lived experiences. Research techniques that privileged the children's realities and gave them an active voice were employed. These included participant observations, classroom interactions, focus group discussions and in-depth interviews. While doing this, I also took into cognisance that children do not live alone but rather engage with and interact with adults, and so teachers and parents were also involved. Focus group discussions and informal conversations were used to elicit data from this group of participants.

The findings of the study have been constituted within four main themes that are directly related to each research question and the chapters that present the analysis have been organised around these themes. These are: children's sense-making around feeling unwell, children's social position and the resources available to them to deal with feeling unwell, the circumstances under which a child's claim of feeling unwell are resisted, modified or accepted, and the different ways in which children and adults frame children's complaints of feeling unwell.

In making sense of and dealing with illness, children constructed a strikingly biomedical version of their body as the foremost point of reference. Contrary to what one might expect in a pluralistic healthcare environment, children did not refer to any other explanatory model, e.g. attributing illness to a spiritual phenomenon when attaching meaning to their sensation of feeling unwell. In short, children explicitly and exclusively biomedicalized feeling unwell. Explaining their illness in this way, they build a diagnosis out of their vague sensations and feelings. They build a diagnosis by relying on non-specific feelings such as '*feeling some way*', particular feelings such as '*pain in the body*', specific feelings in specific parts of the body like '*headache*', visible signs such as '*hot body temperature*', the persistence of symptoms over time and then a named disease category like '*malaria*'. Children were able to attach meanings to their sensations of feeling unwell based on self-reflection on previous experiences with symptoms of a disease category or one that was diagnosed by a health professional, lessons taught in school, the media and their peers. Once a self-diagnosis was established, the children were able to self-medicate or persist in their claims of feeling unwell to adults as strategies to deal with illness.

The analysis also looked at the ways children and adults frame illness and deal with it. It emerged that children and adults have different ways of conceptualizing and framing illness. The biomedicalization of feeling unwell among children is in sharp contrast to the ways in which adults (parents and teachers) interpret children's complaints about feeling ill. While children consistently framed and made sense of their sensations of feeling unwell using biomedical terms and so sought medicines to remedy it, adults unpacked these sensations using a myriad of psychosocial reasons. These reasons revolved around stress, the need for a social obligation to be met and lifestyle patterns. The difference in framing illness then became a source of tension between children and adults. While adults contested children's views about their illness, often resulting in a modification or resistance of the child's complaint, children persisted in their claims. Medicalization then functioned as the children's explanation for disruptions in their daily life while adults viewed it as children's strategies to avoid performing their social obligations such as going to school. To further investigate potential medicalization, I zoomed in on psychological and mental

states: sadness, hyperactivity and learning disabilities. These states were not problematized or biomedically framed by children and adults in relation to everyday needs. Teachers problematized learning disabilities but parents rejected these labels for their children. On the whole, however, the findings showed that in a context where biomedicalization is less prevalent, there are potentials for everyday needs and routines to be medicalized.

In terms of children's social position and the resources available to them to deal with not feeling well, it was observed that interaction patterns between children and adults differed between the two school settings, which had consequences for how illness was dealt with. While the middle class school engaged in negotiation and dialogue, the lower class school resorted to directives in interaction. It is therefore argued that the ways in which adults interact and relate with children is influenced by the power position of the child's parents rather than the values surrounding child-adult interactions in the society. It is within this pattern of interaction that children's competence is constituted, allowed and hindered. In addition, relations between children and adults and how these influence making sense of feeling unwell appeared to be gendered. While girls are hindered by expectations of society to take part in social obligations such as household chores, their success in claiming illness is also enabled by the perception that they are fragile and easily become ill. On the part of boys, expectations that they should be tough enables a successful claim of feeling unwell since they hardly complain of feeling unwell. Children are also shown to be intentional in choosing social relations and connections when they feel unwell in order to make a successful claim and to achieve the desired results.

When children chose to report their sensation of illness, they chose their mother, or a mother figure. This is because of the views they hold of mothers as feeling their pain and so being better able to empathise with them. While they hold these views, mothers themselves believed they can see their children's pain which guides them in making a decision about the genuineness of a claim of illness. These two stances, feeling and seeing the pain, become a source of tension and conflict between children and mothers in ascertaining the truth of a child's illness claim. In the midst of this, mothers rely on the space in which a complaint

is made, the child's past illness history, the need for a social obligation to be met and the presence of visible signs to make decisions. Within situations such as a child's illness history, mothers suspend their knowledge and allow the child's subjective knowledge to take precedence. That is, a certain status of the child, such as having an existing medical condition or having encountered a health professional previously, enables a recognition of competence on the part of the child by adults.

The study provides an essential expansion on the health and illness literature in Ghana by providing children's perspectives, which have been hitherto almost non-existent. The study also shows the different ways in which children and adults frame children's sensations of feeling unwell and so opens up discussions about medicalization in relation to everyday needs and practices in this context. It further provides evidence for a bottom-up approach to medicalization, particularly from a powerless group (children) in society. It has been shown in the findings of the study that one of the likely reasons for children medicalizing their sensations of feeling unwell are their previous encounters with health professionals from whom they received a diagnosis. It is therefore logical to consider that while medicalization may be seen as a bottom-up process in this context, it is to some extent shaped by top-down influencers, even if remotely. That is, doctors and medicines seem to have gained authority among children, thus contesting the authority of children's immediate caregivers (parents and teachers). What this means is that the bottom-up approach to medicalization among the powerless in society as shown in this study is shaped and sustained not necessarily by the custodians of the discourses and knowledge surrounding health and illness in the society, such as parents and teachers in this case, but by the discourses and knowledge of the powerful within the professional sector such as doctors. The study further shows that medicalization can be relevant beyond the clinical realm. Medicalization as evidenced in this study functions as a sense-making tool for children to explain disruptions in their everyday routines. In the case of parents and teachers, medicalization by children reflects a social crisis such as children's reluctance to fulfil their social obligations.

Also, within this context, the study provides an alternative to conceptualizing child-adult interactions. The ways in which children's competence is constituted within interactions in the context of the study has been shown to be influenced by gender and social class. Children who belong to lower class backgrounds are rendered (in) competent through the interaction pattern of directives while their middle class counterparts are allowed to influence decision-making processes around illness because adults interact with them through dialogues and negotiations. Also, the perceptions that are held about male and female children in society as illustrated previously are brought to bear in the extent to which children's participation in making decisions about feeling unwell is allowed or hindered. These findings show that beyond the largely perceived hierarchical relations between children and adults, interactions surrounding illness show that children are related to by adults based on the power positions of the parents of the child and the gender of the child, and not necessarily on societal values around child-adult interactions. This finding thus goes against the general framing of Ghanaian society as one that is gerontocratic.

Again within this setting the pluralistic nature of healthcare is challenged as children's ideas about illness and the remedies sought are mainly in tune with biomedicine. While health research in Ghana has often relied on adult views, this study shows that the dominant perspectives around health are contested by the views of children. This outcome therefore provides relevant and nuanced evidence that may be meaningful to health policy interventions for children especially above the age of five years in Ghana and similar contexts. That is, public health education in general as well as school health policy planning in particular may consider taking into cognizance the views children hold about illness when creating programmes and interventions that target children. In doing this, policymakers will ensure that children's health needs are adequately met and catered for.

Samenvatting

Dit proefschrift gaat over een verandering in het denken over kinderen en medische beslissingen, van kinderen als passief en incompetent om medische beslissingen te maken naar het erkennen van hun vermogen om medische beslissingen te maken. Deze ontwikkelingen komen voort uit een toegenomen focus van de sociale wetenschappen op kinderen als actieve deelnemers aan het sociale leven. Ondanks dat onderzoek hiernaar de afgelopen jaren is toegenomen, is de oproep voor onderzoekers om afstand te nemen van de vraag of kinderen bekwaam genoeg zijn om actief deel te kunnen nemen aan het sociale leven en te focussen op hoe, in specifieke contexten, deze bekwaamheid tot stand komen in relaties tussen kinderen en volwassenen. Bekwaamheid wordt gezien als manieren waarop kinderen engageren met hun sociale omgeving, en als waarover ze onderhandelen, ruzie maken, en mee worstelen binnen specifieke contexten en situaties, tijdens interactieve ontmoetingen met andere leden van de maatschappij. Bekwaamheid is meer dan een cognitieve vaardigheid is of een lineaire ontwikkelingsfase in het leven van kinderen.

Onderzoekers hebben deze redenering gevolgd om onderzoek, gezondheidsonderzoek inclusief, te plaatsen binnen de alledaagse belevingen van kinderen. Deze onderzoeken laten zien dat er variatie is in hoe de bekwaamheid van kinderen gevormd wordt: het is een doorgaand proces in interacties wat blijkt in alledaagse situaties. Echter, voor het grootste deel, zijn deze onderzoeken gedaan in westerse samenlevingen. Binnen niet westerse contexten, in het bijzonder Afrikaanse contexten, laat gezondheidsonderzoek naar de perspectieven van kinderen zien dat kinderen manieren om met hun ziekte bedenken, die anders zijn dan die waarover geschreven wordt in westerse samenlevingen; namelijk kinderen die over gaan op zelfdiagnose en zelfmedicatie. Waar deze studies handig zijn om het leven van kinderen in deze omgevingen te begrijpen, hebben zij beperkingen waardoor het blikveld en focus van mijn studie waardevol is.

Ten eerste, een van de studies die voorziet in essentiële literatuur over 'agency' van kinderen en de omstandigheden van hun ziektes werd uitgevoerd in

een oorlogssituatie. Dit zorgt ervoor dat de samenleving verstoord is en de omstandigheden van kinderen schrijnend is. Anderen focusten op bestaande categorieën van ziekte die veel voorkomen in de omgeving van kinderen zoals koorts, malaria en diarree. Op deze manier worden kinderen gepresenteerd met een ziekte die al bekend is en wordt er gezocht naar hun begrip van deze ziekte. Daarbij, terwijl al deze studies de relaties en interacties tussen kinderen en volwassenen in de ervaring van ziekte in acht nemen; ligt hun focus niet op de sociale positie van het kind, zoals sociale klasse, in het kijken naar de rol die kinderen spelen in het omgaan met hun eigen ziekte. Studies hebben echter laten zien dat de sociale positie van kinderen een cruciale rol speelt in het vormgeven van de relaties die kinderen hebben met volwassenen, en dit heeft consequenties voor de mate waarin het kinderen is toegestaan om deel te nemen aan het maken van beslissingen over hun leven.

Afgaande op de meerderheid van deze studies, vindt dit onderzoek plaats in Ghana waar nog bijna geen gezondheidsonderzoek gedaan is wat direct gekeken heeft naar de kijk van kinderen op hun ervaringen met ziekte. Kind-volwassenen relaties in deze omgeving worden voornamelijk gezien als hiërarchisch en met weinig tot geen ruimte voor kinderen om deel te nemen aan het nemen van besluiten. Het gezondheidszorg systeem kan worden gezien als pluralistisch, met gezondheidszorg beleid dat de gezondheidsbehoeften van kinderen onder de vijf en adolescenten prioriteert. Echter, er lijkt geen gezondheidsbeleid te zijn dat direct richt op kinderen van boven de vijf maar onder de leeftijd van een adolescent, voornamelijk kinderen op de basisschool, omdat zij gezien worden als een gezonde groep. Als een resultaat van deze maatschappelijke waarden en gezondheidsbeleid rondom kinderen in Ghana, wordt er gedacht dat kinderen altijd met de hulp van een volwassene op zoek gaan naar gezondheidszorg en dat zij dit niet zelf doen. Daarbij, dit onderzoek gaat weg van de bestaande categorieën van ziekte en focust op de klachten van kinderen die zich niet lekker voelen, die nog niet zijn voorgelegd aan een medisch professional en dus nog geen diagnose hebben. Dit om de manieren te ontdekken waarop kinderen hun ervaring van ziekte begrijpen en onderhandelen in alledaagse interacties thuis en op school, in een samenleving waar zij minder kans hebben besluitvorming te beïnvloeden.

Dit onderzoek stelt vier onderzoeksvragen in het bijzonder: a) hoe worden ervaren sensaties van 'niet lekker voelen' actief geconstrueerd en mee om gegaan door kinderen in alledaagse interacties? b) hoe beïnvloedt de sociale positie van een kind de constructie van en de strategieën van omgaan met deze gevoelens? c) wat zijn de omstandigheden waaronder de geloofwaardigheid van een kind's claim dat het zich niet lekker voelt geregistreerd, aangepast of geaccepteerd wordt door ouders en leerkrachten? d) wat zijn en hoe worden medische categorieën en behandelingen gebruikt door kinderen en volwassenen om de gevoelens van 'niet lekker voelen' te framen? Ik deed een beroep op een aantal theoretische concepten waaronder: 'agency', generatie, gezondheidzoekend gedrag modellen en medicalisering, als analytische hulpmiddelen om deze studie af te bakenen, mijn onderzoeksvragen te operationaliseren en de aspecten van deze studie uit te leggen zoals uit de analyse bleek.

Om de onderzoeksvragen te beantwoorden, is een etnografie gedaan onder kinderen tussen de zeven en elf jaar oud op twee basisscholen in de Safnarigu gemeente in het noordelijke deel van Ghana. De twee scholen zijn gekozen om hun verschil: de ene school was een middenklasse school de andere was lagere klasse school. Dit liet een vergelijking toe van de interactiepatronen tussen kinderen en volwassenen en hun relevantie in het omgaan met ziekte. Het tweede criterium was gebaseerd op mijn vroegere persoonlijke ervaring als een kind op deze twee scholen als een manier om mij compleet onder te dompelen in en de ervaringen van kinderen te begrijpen. De gebruikte onderzoeksmethoden en technieken werden geleid door de onderzoeks-oriëntatie die kinderen ziet als actieve deelnemers in hun dagelijkse leven en bekwaam in het geven van diepgaande inzichten in hun eigen ervaringen. De gebruikte onderzoekstechnieken prioriteerden de realiteit van kinderen en gaven hen een actieve stem, onder andere participerende observaties, klaslokaal interacties, focusgroep discussies en diepte interviews. Gedurende het onderzoek hield ik in gedachte dat kinderen niet alleen leven, maar omgaan en interacteren met volwassenen. Leerkrachten en ouders zijn dus ook betrokken. Focusgroep discussies en informele gesprekken zijn gebruikt om data te verzamelen van deze groep deelnemers.

De bevindingen van deze studie zijn te verdelen in vier hoofd thema's die direct gerelateerd zijn aan elke onderzoeksvraag, de hoofdstukken die de analyse presenteren zijn georganiseerd rondom deze thema's. Dit zijn: hoe kinderen het 'niet lekker voelen' begrijpen, de sociale positie van kinderen en de beschikbaarheid van middelen om om te gaan met het 'niet lekker voelen'. De omstandigheden waaronder een kind claim zich niet lekker te voelen worden geregistreerd, aangepast of geaccepteerd, en de verschillende manieren waarop kinderen en volwassenen de klachten van 'niet lekker voelen' framen.

Om hun ziekte te begrijpen en er mee om te gaan, construeerden kinderen een opvallend biomedische versie van hun lichaam als voornaamste referentiepunt. In tegenstelling tot wat te verwachten valt in een pluralistische gezondheidszorg omgeving, refereerden kinderen niet tot een andere manier van het uitleggen van hun ziekte, bijvoorbeeld door hun gevoel van ziekte toe te schrijven aan een spiritueel fenomeen. Kortom, kinderen medicaliseerden hun gevoel van ziekte expliciet en uitsluitend. Door hun gevoel op deze manier uit te leggen, creëren zij een diagnose uit vage gevoelens van ziekte. Zij construeerden een diagnose door te verwijzen naar niet specifieke gevoelens als '*zich op een bepaalde manier voelen*', specifieke gevoelens in specifieke delen van het lichaam zoals '*hoofdpijn*', zichtbare tekens zoals '*hoge lichaamstemperatuur*', de aanhoudendheid van symptomen over tijd, en een ziekte categorie die zij '*malaria*' noemden. Kinderen konden betekenissen verbinden aan hun 'niet lekker voelen' op basis van zelfreflectie, van ervaringen met symptomen in het verleden of een ziekte categorie die gediagnosticeerd was door een professional, lessen op school, in de media, of door leeftijdgenoten. Wanneer er een zelfdiagnose was, konden kinderen zichzelf 'behandelen' (self-medicate) of volharden in hun claims zich niet lekker te voelen naar volwassenen als een manier om om te gaan met hun ziekte.

De analyse keek ook naar de manieren waarop kinderen en volwassenen ziekte frameden en er mee om gingen. Het bleek dat kinderen en volwassenen verschillende manieren hebben van het conceptualiseren en framen van ziekte. De medicalisering van het 'niet lekker voelen' onder kinderen stond in scherp contrast tot de manieren waarop volwassenen (ouders en leerkrachten) de

klachten en gevoelens van ziekte van kinderen interpreteerden. Waar kinderen hun gevoelens van zich niet lekker voelen consistent frameden en uitlegden in medische termen en daardoor op zoek gingen naar medicijnen om het te verhelpen, gebruikten volwassenen een grote hoeveelheid psychosociale redenen voor deze gevoelens van kinderen. Voornamelijk stress, de behoefte tot het vervullen van sociale verplichting en leefstijl patronen. Het verschil in het framen van ziekte werd op deze manier een bron van spanning tussen kinderen en volwassenen. Hoewel volwassenen de kijk van kinderen op hun ziekte tegenspraken, wat vaak resulteerde in een aanpassing of verzet van de klachten van kinderen, hielden kinderen vaak vast aan hun claims. Medicalisering functioneerde als uitleg van kinderen voor de verstoring van hun dagelijks leven terwijl volwassenen het zagen als strategieën van kinderen om sociale verplichtingen, zoals naar school gaan, te vermijden. Om de potentiële medicalisering verder te onderzoeken, zoomde ik in op psychologische en mentale stadia: verdrietigheid, hyperactiviteit, en leerstoornissen. Deze stadia warden niet geproblematiseerd of medisch geframed door kinderen en volwassenen in relatie tot hun dagelijkse behoeften. Leerkrachten problematiseerden leerstoornissen, maar ouders verwierpen deze labels voor hun kinderen. Over het algemeen, laten de bevindingen echter zien dat in een context waar medicaliseren minder aanwezig is, er ook mogelijkheden zijn om alledaagse behoeften en routines te medicaliseren.

Op het gebied van de sociale positie van kinderen en de middelen die kinderen tot hun beschikking hadden om om te gaan met het niet lekker voelen, kon geobserveerd worden dat interactie patronen tussen kinderen en volwassenen verschilden tussen de twee scholen, die consequenties hadden voor hoe er met ziekte werd om gegaan. Terwijl de kinderen op de middenklasse school onderhandelden en de dialoog aangingen, grepen de kinderen op de lagere klasse school bevelen in interactie. Er wordt daarom gezegd dat de manieren waarop volwassenen omgaan met en zich verhouden tot kinderen beïnvloed wordt door de machtspositie van de ouders van kinderen, in plaats van door de maatschappelijke waarden rondom kind-volwassenen interacties. Binnen dit patroon van interactie worden de competenties van kinderen vastgesteld, toegelaten en gehinderd. Daarbij, relaties tussen kinderen en volwassenen en hoe

deze invloed hebben op het begrijpen van het niet lekker voelen blijken gendered. Terwijl meisjes gehinderd worden door maatschappelijke verwachtingen om mee te doen aan sociale verplichtingen zoals huishoudelijke taken, wordt hun succes in het claimen van ziekte mogelijk gemaakt door de perceptie dat meisjes fragiel zijn en gemakkelijk ziek worden. Voor jongens, stelt de verwachting dat zij sterk zijn ze in staat om succesvol te claimen dat zij zich niet lekker voelen omdat zij zelden klagen over zich niet lekker voelen. Gezien kan worden dat kinderen bewust sociale relaties en connecties kiezen als zij zich niet lekker voelen om zo een succesvollere claim te maken en de gewenste resultaten te behalen.

Wanneer kinderen kiezen te vertellen over hun gevoel van ziekte, doen zij dit vaak aan hun moeder of een moederfiguur. Dit omdat zij denken dat moeders hun pijn kunnen voelen en daardoor beter in staat zijn empathie met ze te hebben. Ondanks dat kinderen dit denken, dachten moeders de pijn van hun kinderen te kunnen zien en lieten zich daardoor leiden in het beoordelen van de oprechtheid van de claim van ziekte. Deze twee opvattingen, het voelen en het zien van pijn, zijn een bron van spanning en conflict tussen kinderen en moeders in het beoordelen van de waarheid van een kinds claim van ziekte. Daarbij, gaan moeders af op waar de claim van ziekte gemaakt wordt, de ziektegeschiedenis van een kind, de behoefte om te voldoen aan sociale verplichtingen en de aanwezigheid van zichtbare tekens wanneer zij beslissingen maken. Binnen bijvoorbeeld een kinds geschiedenis met ziekte, pauzeren moeders hun kennis en staan toe dat de subjectieve kennis van een kind op de voorgrond treden. Een bepaalde status van het kind, zoals het hebben van een bepaalde medische aandoening of een eerdere ontmoeting met een medisch professional, zorgt ervoor dat volwassenen de competenties van een kind erkennen.

Deze studie zorgt voor een essentiële uitbreiding van de literatuur over gezondheid en ziekte in Ghana, door het perspectief van kinderen te laten zien, een perspectief wat hiervoor bijna niet bestond. De studie laat ook de verschillende manieren waarop kinderen en volwassenen de gevoelens van niet lekker voelen bij kinderen framen en geeft voer voor discussie over medicalisering in relatie tot alledaagse behoeften en praktijken in deze context. Verder geeft het bewijs voor een bottom-up aanpak van medicalisering, in

het bijzonder door een groep zonder maatschappelijke macht (kinderen). De bevindingen laat zien dat eerdere ontmoetingen met medisch professionals en daarbij gestelde diagnoses een van de waarschijnlijke redenen is voor de medicalisering van de gevoelens van ziekte van kinderen. Het is dan ook logisch om dit bottom-up proces van medicalisering te zien als een proces dat top-down beïnvloed wordt, al is het van een afstand. Dokters en medicijnen lijken onder kinderen in autoriteit te winnen, en daarmee de autoriteit van directe verzorgers (ouders en leerkrachten) te bevragen. Dit betekent dat de bottom-up medicalisering onder hen zonder maatschappelijke macht, zoals deze studie laat zien, duurzaam gevormd wordt door discours en macht van professionals zoals dokters; en niet door het discours en de kennis over gezondheid en ziekte van, in dit geval, ouders en leerkrachten. Ook laat de studie zien dat medicalisering relevant kan zijn buiten een klinische omgeving. Medicalisering functioneert als een manier waarop kinderen veranderingen in hun alledaagse routine kunnen uitleggen. In het geval van ouders en leerkrachten, laat medicalisering een sociale crisis zien, zoals onbereidheid van een kind om te voldoen aan sociale verplichtingen.

Binnen deze context geeft deze studie ook een alternatief voor het conceptualiseren van de kind-volwassenen interacties. De manier waarop de competenties van kinderen vastgesteld wordt binnen interacties, wordt beïnvloedt door gender en sociale klasse. Kinderen die tot de lagere klasse behoren worden als (in) competent gezien door bevelende interactie patronen, waar het kinderen uit de middenklasse was toegestaan om beslissingen rondom ziekte te beïnvloeden doordat ouders met hen in dialoog gingen en onderhandelden. Ook zorgden de eerder geïllustreerde verschillen in maatschappelijke opvatting over jongens en meisjes, voor een verschillende mate waarin de participatie van kinderen in het maken van beslissingen over het niet lekker voelen werd toegestaan of verhinderd werd. Deze bevindingen laten zien dat, interacties rondom ziekzijn gebaseerd zijn op machtsposities van ouders en kinderen en het gender van het kind, en niet noodzakelijkerwijs op maatschappelijke waarden rondom kind-volwassenen relaties. Dit druist in tegen een algemeen beeld van de Ghanese maatschappij als gerioncratisch.

Binnen deze setting wordt de pluralistische aard van gezondheidszorg bevestigd door de ideeën van kinderen over ziekte en remedies die voornamelijk gezocht worden in het medische circuit. Terwijl gezondheidsonderzoek in Ghana vaak afging op de ideeën van volwassenen, laat deze studie zien dat dominante meningen over gezondheid bevestigd worden in de ideeën van kinderen. Deze uitkomst geeft relevant en genuanceerd bewijs dat van betekenis kan zijn voor gezondheidsbeleid, voornamelijk wat betreft kinderen boven de vijf jaar in Ghana en vergelijkbare contexten. Gezondheidseducatie in het algemeen evenals gezondheid beleid van scholen in het bijzonder, zouden de ideeën van kinderen in overweging kunnen nemen bij het maken van programma's en interventies gericht op kinderen. Hiermee zullen beleidsmakers ervoor zorgen dat er aan hun de gezondheidsbehoeften voldaan wordt.

Riassunto

La presente tesi trae origine da un cambiamento di concezione: i bambini, da esseri viventi passivi e incompetenti nell'assunzione di decisioni in campo sanitario, sono ora riconosciuti capaci di prendere decisioni. Questi sviluppi sono il risultato di un crescente interesse della ricerca scientifico-sociale per i bambini in quanto partecipanti attivi alla vita sociale. Anche se la ricerca in questo ambito si è sviluppata nel corso degli anni, i ricercatori sono stati chiamati a passare dal tentativo di stabilire se i bambini siano competenti nel partecipare attivamente alla vita sociale, al concentrarsi su come si forma la competenza nelle relazioni tra bambini e adulti in contesti specifici. La competenza quindi deve essere considerata come il modo in cui i bambini si confrontano con il proprio ambiente sociale, oltre che come un qualcosa con cui fare i conti, di cui discutere e da affrontare con fatica negli incontri interattivi con gli altri membri della società in situazioni e contesti specifici, piuttosto che come un'abilità cognitiva o una fase di sviluppo lineare nella vita dei bambini.

I ricercatori hanno seguito questa linea di pensiero per collocare ricerche comprendenti studi sulla salute nell'ambito delle esperienze quotidiane vissute dai bambini. Gli studi hanno dimostrato che esiste una variazione nelle modalità di formazione della competenza dei bambini: si tratta di un processo in fieri nelle interazioni, che appare evidente nella quotidianità. Tuttavia, dette ricerche sono state condotte in gran parte nelle società occidentali. Nell'ambito di contesti non occidentali, in particolare africani, le ricerche sanitarie incentrate sul punto di vista dei bambini hanno dimostrato che essi escogitano modi di affrontare la malattia diversi da quelli propri delle società occidentali, in particolare ricorrono all'autodiagnosi e all'automedicazione. Benché questi studi siano utili per capire la vita dei bambini in tali contesti, sono stati identificati limiti che danno senso alla portata e al centro di interesse del mio studio.

In primo luogo, uno degli studi che fornisce riferimenti essenziali sull'agentività dei bambini in situazioni di malattia è stato condotto in un contesto bellico, che crea sconvolgimenti nella società e condizioni terribili per i bambini. Altri si sono concentrati su categorie di malattie già esistenti quali febbre, malaria

e diarrea, comuni negli ambienti frequentati dai bambini. In questo modo, ai bambini si presenta una malattia che ha già un nome e si procede quindi con l'individuazione della loro comprensione della malattia stessa. Inoltre, anche se tutti questi studi prendono in considerazione relazioni e interazioni tra bambini e adulti nell'esperienza della malattia da parte dei bambini, il loro specifico interesse non è diretto alla posizione sociale del bambino, ad esempio alla classe sociale, nell'approfondire il ruolo che essi svolgono quando si trovano ad affrontare la malattia da soli. Tuttavia, alcuni studi hanno dimostrato che la posizione sociale dei bambini riveste un ruolo fondamentale nel plasmare le relazioni che i bambini intrattengono con gli adulti, con conseguenze sulla misura in cui ai bambini è consentito prendere parte al processo decisionale che interessa le loro stesse vite.

A differenza della maggior parte di questi studi, il presente lavoro è ambientato in Ghana, dove non è stata svolta quasi alcuna ricerca sanitaria volta ad indagare direttamente il punto di vista dei bambini sulle proprie esperienze di malattia. Le relazioni tra bambini e adulti in questo contesto sono percepite principalmente come rigidamente gerarchiche, con il ruolo dei bambini nel processo decisionale minimo o assente. Il sistema sanitario è riconosciuto come pluralistico e caratterizzato da una politica sanitaria che dà la priorità alle esigenze dei bambini di età inferiore ai cinque anni e agli adolescenti. Tuttavia, sembra che coloro che hanno superato i cinque anni di età e non hanno ancora raggiunto l'adolescenza, presenti soprattutto nella scuola elementare, non siano oggetto di alcuna politica sanitaria specifica, poiché vengono considerati in buone condizioni di salute. Il risultato di questi valori sociali e della politica sanitaria infantile ghanese è che si ritiene che essi non cerchino di migliorare la propria salute da soli, quanto piuttosto attraverso l'assistenza degli adulti. Inoltre, il presente studio si allontana dalle categorie di malattie esistenti per concentrarsi su bambini che rivendicano di non sentirsi bene, ma che non sono stati ancora visitati da personale medico e quindi non hanno ricevuto alcuna diagnosi. Ciò consente di esplorare le modalità con cui, all'interno di una società in cui hanno meno probabilità di influire sul processo decisionale, i bambini trovano un senso e gestiscono le proprie esperienze di malattia nelle interazioni quotidiane a casa e a scuola.

Nello specifico, lo studio si è posto quattro domande nell'ambito della ricerca: **a)** Come sono attivamente costruite e affrontate dai bambini nelle interazioni quotidiane le sensazioni di malessere percepite? **b)** In che modo la posizione sociale di un bambino influenza la costruzione e le strategie di gestione di dette sensazioni? **c)** Quali sono le circostanze in cui l'autenticità della rivendicazione di un bambino di non sentirsi bene viene contrastata, modificata o accettata da genitori e insegnanti? **d)** Come e quali categorie e cure mediche vengono utilizzate da bambini e adulti per formulare le sensazioni di malessere dei bambini? Si è fatto ricorso a un certo numero di concetti teorici, tra cui agentività, generazione, modelli comportamentali di miglioramento della salute e medicalizzazione, quali strumenti analitici per contribuire a delineare lo studio, operationalizzare le domande della mia ricerca e spiegare gli aspetti dello studio man mano che emergevano dall'analisi.

Per rispondere alle domande della ricerca, è stato realizzato uno studio etnografico tra i bambini dai sette agli undici anni di età in due scuole elementari nella municipalità di Sagnarigu nel Ghana settentrionale. Le due scuole sono state scelte perché diverse: una apparteneva al ceto medio e l'altra a una classe sociale più bassa. Ciò ha consentito di mettere a confronto gli schemi di interazioni tra bambini e adulti e la loro pertinenza nell'affrontare la malattia. Il secondo criterio era basato sulla mia esperienza personale di bambino in entrambe le scuole, che mi ha permesso di immergermi totalmente e di comprendere le esperienze dei bambini. Le tecniche e i metodi di ricerca utilizzati sono stati guidati dall'orientamento che vede i bambini come partecipanti attivi alla propria vita quotidiana e soggetti in grado di fornire approfondimenti sulle esperienze vissute. Sono state utilizzate tecniche di ricerca che privilegiavano le realtà dei bambini e davano loro la possibilità di esprimersi attivamente, ad esempio osservazioni partecipanti, interazioni in aula, discussioni di gruppi di interesse e interviste approfondite. Durante questo percorso, ho anche preso atto del fatto che i bambini non vivono soli, ma piuttosto si confrontano e interagiscono con gli adulti, tanto che anche insegnanti e genitori erano coinvolti. Sono state utilizzate discussioni del gruppo di interesse e conversazioni informali al fine di ottenere dati da questo gruppo di partecipanti.

I risultati dello studio rientrano in quattro temi principali, direttamente collegati a ciascuna domanda della ricerca, e i capitoli di presentazione dell'analisi sono stati organizzati intorno a questi quattro temi, ovvero: la capacità dei bambini di trovare un senso al malessere, la posizione sociale dei bambini e le risorse a loro disposizione per gestire il malessere, le circostanze in cui la rivendicazione di un bambino di non sentirsi bene viene contrastata, modificata o accettata, e i diversi modi in cui bambini e adulti formulano le rivendicazioni del malessere provato dai bambini.

Nel trovare un senso e affrontare la malattia, i bambini hanno costruito una versione sorprendentemente biomedica del proprio corpo quale principale punto di riferimento. Contrariamente a ciò che sarebbe lecito aspettarsi in un ambiente sanitario pluralistico, i bambini, nell'assegnare significato alla loro sensazione di malessere, non hanno fatto riferimento ad altri modelli esplicativi, ad esempio l'attribuzione della malattia a un fenomeno spirituale. In sostanza, i bambini hanno biomedicalizzato la sensazione di non sentirsi bene in modo esplicito ed esclusivo. Spiegando la propria malattia in questo modo, costruiscono una diagnosi a partire da sensazioni e percezioni vaghe, e lo fanno basandosi su sensazioni non specifiche quali *"avvertire un disturbo"*, particolari come *"un dolore nel corpo"*, specifiche in parti precise del corpo come *"mal di testa"*, segni visibili come *"febbre alta"*, sintomi persistenti nel tempo e una categoria di malattia ben definita come la *"malaria"*. I bambini erano in grado di assegnare un significato alle proprie sensazioni di malessere sulla base di un'autoriflessione relativa alle precedenti esperienze con i sintomi di una categoria di malattia o di una patologia diagnosticata tramite un operatore sanitario, lezioni apprese a scuola, i mezzi di comunicazione e il gruppo dei pari. Una volta definita l'autodiagnosi, i bambini potevano curarsi da soli o persistere nelle rivendicazioni di malessere rivolte agli adulti, come strategie per affrontare la malattia.

L'analisi ha anche preso in esame in che modo bambini e adulti formulano e gestiscono la malattia: è emerso che hanno modi diversi di concettualizzare e formulare la malattia. La biomedicalizzazione della sensazione di malessere tra i bambini contrasta nettamente con il modo in cui gli adulti (genitori e insegnanti) interpretano le rivendicazioni di malessere dei bambini. Mentre i bambini

formulavano e davano un significato in modo coerente alle loro sensazioni di malessere utilizzando termini biomedici e di conseguenza cercavano farmaci per porvi rimedio, gli adulti scomponavano queste sensazioni facendo ricorso a una miriade di motivazioni di carattere psicologico. Le motivazioni erano impregnate sullo stress, sulla necessità di rispettare un obbligo sociale e sui modelli di stili di vita. La differenza nella formulazione della malattia si trasformava quindi in una fonte di tensione tra bambini e adulti. Mentre gli adulti contestavano il modo in cui i bambini vedevano la malattia, provocando spesso una resistenza o una modifica della rivendicazione del bambino, i bambini persistevano nel loro punto di vista. Mentre la medicalizzazione fungeva da spiegazione da parte dei bambini dello sconvolgimento della loro vita quotidiana, gli adulti la consideravano una strategia dei bambini volta a evitare il rispetto degli obblighi sociali, come frequentare la scuola. Per approfondire la potenziale medicalizzazione, ci si è concentrati sugli stati psicologici e mentali: tristezza, iperattività e disabilità di apprendimento. Tali stati non erano problematizzati né formulati in senso biomedico da bambini e adulti in relazione alle esigenze quotidiane. Gli insegnanti problematizzavano le disabilità di apprendimento, ma i genitori rifiutavano queste etichette per i propri figli. Tuttavia, complessivamente i risultati hanno mostrato che in un contesto in cui la biomedicalizzazione è meno prevalente, esiste il potenziale per medicalizzare le routine e le esigenze quotidiane.

In termini di posizione sociale dei bambini e di risorse a loro disposizione per gestire la sensazione di malessere, si è osservato che gli schemi di interazione tra bambini e adulti erano diversi tra i due ambienti scolastici, con conseguenze sul modo di affrontare la malattia. Mentre la scuola del ceto medio si affidava al dialogo e al confronto, la scuola della classe sociale più bassa faceva ricorso a raccomandazioni nelle interazioni. Si sostiene pertanto che le modalità con cui gli adulti interagiscono e si relazionano con i bambini sono influenzate dalla posizione di potere dei genitori del bambino piuttosto che dai valori che sottendono le interazioni tra bambini e adulti nella società. È nell'ambito di un tale schema di interazioni che la competenza dei bambini si forma ed è consentita o ostacolata. Inoltre, le relazioni tra bambini e adulti e la loro influenza sulla capacità di trovare un senso alla sensazione di malessere sembrano essere

associate al genere. Benché siano ostacolate dalle aspettative della società a partecipare a obblighi sociali quali i lavori domestici, le ragazze riescono a rivendicare di essere ammalate perché sono percepite fragili e facili ad ammalarsi. Per quanto riguarda i ragazzi, ci si aspetta che siano più robusti e questo consente loro di rivendicare di essere ammalati proprio perché è raro che lamentino di sentirsi male. Risulta inoltre evidente l'intenzionalità con cui i bambini scelgono i rapporti e le relazioni sociali in caso di malessere, con l'obiettivo di rivendicare la propria malattia e di ottenere i risultati desiderati.

Quando i bambini hanno deciso di esprimere la loro sensazione di malessere, hanno scelto la madre o comunque una figura materna, presumendo che le madri siano in grado di sentire la loro sofferenza e riescano a empatizzare meglio con loro. Questa è l'opinione dei bambini, ma le stesse madri ritengono di saper vedere la sofferenza di un figlio e che tale capacità le guidi nell'assumere una decisione sull'autenticità del loro malessere. Questi due atteggiamenti, sentire e vedere la sofferenza, generano tensione e conflitto tra bambini e madri al momento di accertare l'autenticità del malessere dei figli. In tale contesto, prima di decidere, le madri tengono conto dello spazio in cui il figlio rivendica il malessere, delle malattie che ha avuto in passato, dell'esigenza di rispettare un obbligo sociale e della presenza di segni visibili. In situazioni quali le precedenti malattie di un figlio, le madri sospendono la propria conoscenza e lasciano che sia la conoscenza soggettiva del figlio ad avere la precedenza. In altre parole, un determinato stato del bambino, ad esempio essere affetto da una patologia o aver già incontrato un operatore sanitario, consente il riconoscimento della competenza del bambino da parte degli adulti.

Lo studio rappresenta un ampliamento essenziale della letteratura relativa a salute e malattia in Ghana, presentando il punto di vista dei bambini, finora quasi totalmente assente. Inoltre, lo studio illustra le diverse modalità con cui bambini e adulti formulano le sensazioni di malessere dei bambini, aprendo a una discussione sulla medicalizzazione in relazione alle esigenze e alle pratiche quotidiane in questo contesto. Fornisce anche prove di un'impostazione della medicalizzazione dal basso verso l'alto, in particolare dalla prospettiva di un gruppo (quello dei bambini) che non ha potere nella società. I risultati dello studio

hanno dimostrato che una delle ragioni più probabili per la medicalizzazione operata dai bambini delle proprie sensazioni di malessere è costituita da precedenti incontri con operatori sanitari dai quali hanno ricevuto una diagnosi. È pertanto logico avanzare la considerazione che, anche se la medicalizzazione può essere vista come un processo dal basso verso l'alto in questo contesto, essa viene in una certa misura modellata da fattori di condizionamento dall'alto verso il basso, benché remoti. In altre parole, sembra che l'autorevolezza di medici e farmaci sia andata aumentando tra i bambini, entrando in competizione con l'autorevolezza di chi si prende costantemente cura di loro: genitori e insegnanti. Ciò significa che una medicalizzazione impostata dal basso verso l'alto tra chi non ha potere nella società, come risulta dal presente studio, è modellata e sostenuta non necessariamente dai depositari delle dissertazioni e delle conoscenze relative a salute e malattia nella società (genitori e insegnanti in questo caso), ma dalle dissertazioni e dalle conoscenze di chi detiene il potere in ambito professionale, ad esempio i medici. Lo studio mostra inoltre che la medicalizzazione può assumere rilevanza al di là del dominio clinico. La medicalizzazione, così come emerge dal presente studio, consente ai bambini di trovare un senso e di spiegare lo sconvolgimento della loro quotidianità. Nel caso di genitori e insegnanti, la medicalizzazione dei bambini rispecchia una crisi sociale, quale la loro riluttanza a rispettare i propri obblighi nei confronti della società.

In tale contesto, lo studio fornisce un'alternativa alla concettualizzazione delle interazioni tra bambini e adulti. Le modalità con cui si forma la competenza dei bambini nelle interazioni nell'ambito dello studio hanno dimostrato di subire l'influenza del genere e della classe sociale. I bambini provenienti da una classe sociale più bassa sono resi (in)competenti attraverso lo schema interattivo di raccomandazioni, mentre quelli appartenenti al ceto medio hanno la possibilità di influenzare i processi decisionali relativi alla malattia, dal momento che gli adulti interagiscono con loro attraverso il dialogo e il confronto. Inoltre, le percezioni che sussistono nella società in merito a maschietti e femminucce, come illustrato in precedenza, hanno ripercussioni sulla possibilità di consentire o ostacolare la partecipazione dei bambini alle decisioni relative alla sensazione di malessere. Da questi risultati si evince che, al di là delle relazioni tra adulti

a bambini, ampiamente percepite come gerarchiche, le interazioni relative alla malattia mostrano che gli adulti si interfacciano con i bambini sulla base delle posizioni di potere dei genitori del bambino e del genere del bambino, e non necessariamente sulla base di valori sociali relativi alle interazioni tra bambini e adulti. Si tratta quindi di una scoperta che contraddice la concezione generale della società ghanese come gerontocratica.

Sempre in questo contesto, viene messa in discussione la natura pluralistica del sistema sanitario, poiché le idee dei bambini sulla malattia e sui rimedi a cui ricorrere sono complessivamente in sintonia con la biomedicina. Anche se le ricerche relative alla sanità ghanese hanno spesso fatto affidamento sul punto di vista degli adulti, il presente studio mostra che la visione dominante relativa alla salute è oggetto di contestazione da parte della visione che ne hanno i bambini. Pertanto, i risultati forniscono prove pertinenti e articolate che potrebbero tornare utili ai fini di interventi sulle politiche sanitarie, in particolare per i bambini di almeno cinque anni di età in Ghana e in contesti simili. In altri termini, l'istruzione sanitaria pubblica in generale e la pianificazione delle politiche sanitarie a scuola in modo specifico potrebbero decidere di tener conto dei punti di vista dei bambini in merito alla malattia, in occasione dell'elaborazione di programmi e interventi a loro dedicati. Questa impostazione consentirà ai responsabili delle politiche di rispettare e soddisfare in modo adeguato le esigenze dei bambini in tema di salute.



Children's Matters: Negotiating illness in everyday interactions at home and school in Ghana

Focusing on sensations of not feeling well or illness complaints that have not yet been given a diagnosis by a health professional, this research asks how children in an adult-centered and pluralistic context of health care negotiate their illness experiences at home and school. The ways in which children actively construct, frame and deal with their illness, and the role their social position (gender and social class) in the Ghanaian context plays in this process is explored. The research highlights how children intentionally navigate relations and interactions with adults, make use of their social and physical environment to contest, self-diagnose, self-medicate and to deal with their sensations of not feeling well.

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