Original Article

Perspectives of the influence of social determinants on health empowerment: a qualitative study of tribal women in Udaipur, north India

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Received: 4 June 2021 **Accepted:** 19 Aug 2021 **published:** 20 Aug 2021

Abstract

Background: Improvement in the women's health promotes the sustainable development goal of good health and well-being. Providing equal opportunities and access to the resources would not empower women unless they are given more autonomy and power to take decisions. The current study explored the viewpoints of women about the influence of structural, socio-cultural determinants on health understanding and decision making.

Methods: An exploratory qualitative study design and interpretive epistemological approach were used to conduct the study among purposively selected16 adult women in Udaipur sub division located in the Trans Himalayan region of north India. Data was analyzed using the thematic content analysis and constant comparative approach.

Results: Based on the similarities and commonalities of the responses of the participants four broader themes and ten subthemes were identified. The study found that determinants like socioeconomic conditions, poor health literacy, less autonomy, housing conditions, harsh winters and distance negatively affect women's health. Women identified health illiteracy, time, and lack of basic health facilities as the barriers to access the healthcare system.

Conclusion: The study results recommended the need for early inclusion of women as one of the stakeholders of health system. Participatory approach by health professionals can build the trust between the health care system and women. On policy level the government needs to improve the education for girls, employment and health infrastructure. More studies on women's perspectives towards underlying social determinants would be required for better health policies.

Keywords: Communication Barriers; Empowerment; Health; Social Determinants of Health; Women's Health Services.

Cite this article as: Thakur RS. Perspectives of the influence of social determinants on health empowerment: a qualitative study of tribal women in Udaipur, north India. *Soc Determinants Health*. 2021;7(1):1-10 DOI: http://dx.doi.org/10.22037/sdh.v6i1.35090

Introduction:

World Health Organization has defined health "as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1). Socioeconomic conditions, early education, security, gender bias, working conditions, and power to access the healthcare system are the major social determinants of health (2, 3). Globally, around 1,600 women, (99% of these are in

developing countries) die daily due to preventable maternal and other health issues

Promoting women health strengthens the 4th and fifth goal of the Sustainable Development Program. Socioeconomic conditions of women predict the choice for the place of delivery. The study conducted by Sahoo *et al*., (4) showed that 43% of the women with weak wealth index or low employment preferred home for delivery. Gender leads to unequal distribution of health in low-income communities. Women's health in Indian tribes reflected 15.3% higher rate of malnutrition in women than men. Kshatriya and Acharya (5) conducted a study among nine major tribes of India and found that odds of risk for severe malnutrition among females were 3.3 in comparison to males. Women in these tribes had limited access to income and nutritional facilities in comparison to men. Women working in low-paid jobs are at high risk of developing mental disorders and anxiety. Travasso *et al*. (6) conducted a study among 48 urban working women living in urban slums of Banglore, India. Adverse working conditions, like no leave while working as domestic workers, influenced the mental health of women. The influence of distance on institutional delivery in rural India was studied using a secondary analysis of quantitative data was conducted by Kumar *et al., (*7). The study found that with each kilometer distance from the nearest health facility, there was a 4.4% decline in institutional delivery. Shreshta (8) studied the status of gender regarding education, employment, and decision making in household matters and healthcare access. Due to poor ownership in properties and low social status of women, there was a delay in accessing maternal healthcare.

A systematic review of about 137 studies on domestic violence against women in India, conducted by Kalokhe *et al*. (9), revealed that about 41% of the women had experienced domestic violence during their lifetime.

The current study aimed to explore the perspectives of women toward the social determinants of health. The study evaluated the underlying social, cultural, and physical factors of health and explored how women participate in decisions related to health.

Methods

The research inquiry was based on the interpretive epistemology. The researcher examined women's perspectives using the epistemological approach of social constructivism. Positionality of the researcher during the current study was of a male veterinarian working one year previous to conducting the interviews with the natives of Udaipur.

Research design

The study was conducted using a qualitative design. Women's perspectives on the influence of social and environmental determinants served as first-order constructs. Using these interpretations or first-order constructs, the researcher made specific interpretations known as second-order constructs.

Setting

The study was carried out in the Udaipur subdivision of district Lahaul and Spiti. Udaipur is located on the sides of river Chandra Bhaga at an altitude of 2,742 meters from sea level in Trans-Himalayan regions of north India

Participants

The study identified information-rich participants using the purposive sampling method as purposive sampling method was more appropriate for identification of participants that could provide detailed information on the subject. 16 no. of participants were recruited for the study.

Inclusion and exclusion criteria

Women above the age of 18 years living in Udaipur area for at least five years and knowing Hindi language were included in the study. Excluded were the individuals who either declined the consent or were considered vulnerable due to severe illness.

Details of data gathering

Interview guide: Based on the research question, literature review, and pilot testing an interview guide was prepared. The semi-structured format was used to develop an interview guide to unfold the rich descriptive data on the personal experiences and perspectives of the participants (10). The key topics for the guide included open-ended questions on how socioeconomic conditions, early life, education employment, power, and gender bias affect the understanding of women toward health.

Pilot interviews: Pilot interviews were conducted with the two participants (P1 and P2) who met the recruitment criteria. Piloting was done to ensure whether the participants understood the purpose of the questions as desired by the researcher (10).

Data collection procedure: The researcher scheduled the interviews with the recruited participants. Interviews were fixed at the participant's home with prior intimation. The researcher first briefed the participants about the purpose and procedure of interviews and obtained written informed consent. The interviews were conducted in the Hindi language and later transcribed into English by the researcher (11). The researcher communicated slowly in a smooth tone and ensured that the conversation did not impose any physical or mental pressure on the participants. The information was audio-recorded, with the help of a mobile recorder, for transcription. Each step of the research was carefully planned and noted for better transferability (12). In the end, the researcher thanked the participants for participation and sparing time.

Ethical considerations

The ethical approval was obtained from the ethical committee of the University of Liverpool on dated 23/08/2017 and 3/11/2017. The study complied with the exemption criteria as defined by the Code of Federal Regulations concerned with the protection of human research subjects (HHS, 2010). The real names of the participants were replaced with pseudonyms as P1, P2, and P3..., and P16 to maintain confidentiality. The researcher assured to use the data for research purpose and destroy it after five years. Hard copies were stored in the locked cabinet while digital data was given password protection. (13, 14).

Data analysis

Thematic content analysis and constant comparative approach were used to process the data (15). All the sixteen transcripts were color-coded (excerpt of the color-coded transcript is included as an appendix 8) after reading through repeatedly (15). The quotations were grouped into meaningful units based on the similarities and commonalities of the responses (16). Use of keywords, statements, and repetitions of the responses was used to establish reliability. The meaningful units were grouped into well-defined codes. The uniquely colored codes supported by the quotations from the original transcripts were collated on a separate theme codebook (table 1). Based on the patterns and similarities of the codes, these were grouped into the broader conceptual subcategories known as subthemes. Using the data, literature review, and theoretical concepts, these subthemes were further abstracted into broader categories known as themes as shown in table 1. Finally, the researcher drew the conclusions and recommendations from these subthemes and themes (16).

Table 1: Theme code book

Themes/Categories	Subthemes /Subcategories	Codes
1.**Women's perspectives towards health**	1.1What women mean by health	*1.1.1Women considered health problems as normal part of growing and aging* *1.1.2 Postpone their health decisions over work* *1.1.3 Prioritize family and children over their own health*
2.Women's.Perspectives on the Influence of Social Determinants on women health	2.1Socioeconomic conditions	*2.1.1 Sometimes women need to postpone treatment due to financial problems* *2.1.2 Sometimes women try to manage with little medicines or postpone the treatment*
	2.2 Education	*2.2.1 Women feel the need for education in later stages of their lives* *2.2.2 Most of the women left studies after secondary level as they got married*
	2.3 Gender discrimination	*2.3.1 Women have not faced any discrimination due to gender* *2.3.2 Occasionally there are cases of discrimination against women*
	2.4 Domestic violence	
	2.5 Working conditions of women	*2.5.1 Women feel that being in job equip women better in taking care of themselves and family*
3. Barriers that women face in accessing the health care system	3.1 Barriers at individual level	*3.1.1Money and time are among the most important barriers women come across while accessing the health care system* *31.2.1 Distance, lack of experts and money are major barriers in front of women while accessing the health care system*
	3.2 Barriers at community and broader level	*3.2.2 Snowfall in winter further aggravate the conditions of women and their health*
	3.3Participation in the decision making	*3.3.1 In some of the families, women have to delay their health checkups as decisions are made by the elders who may overlook their voices*
4. Factors which women think can improve their health	4.1 Healthcare system	*4.1.1The local hospital should have basic diagnostic facilities like ultrasound* *4.1.2Local administration should also make proper arrangement to meet emergency and natural calamities dental care and child health care*

Results

Based on the commonalities and similarities in the views expressed by women through interviews, five major themes and ten subthemes were identified. The themes included women's perspectives towards health, women's perspectives on the influence of social determinants on women's health, barriers that women face in accessing the health care system, and the factors, which women thought, could improve their health.

Theme 1- Women's perspectives towards health

Various social determinants influence women's ability to participate and take

decisions related to health and well-being. Some women felt that for them, the situation had not improved much over the years, and they were not given freedom. Many women felt less powerful and had little control over their health, and they did not enjoy freedom and autonomy.

P5: In my opinion, the situation has not changed much. Even today, we need to ask men for everything. The situation has not improved much.

Subtheme 1.1: What women mean by health

Most of the women believed and accepted ailments like high blood pressure, joint pains, and headaches as a normal part of life, as they grew older. The majority of women shared that they did not comply with the medical treatment schedule despite having problems and did not bother to go for preventive checkups.

P11: The doctor was also saying that I should be careful and do regular checkups. I am bit careless about myself as there are many factors. I also have problems with my uterus.

Theme 2- Women's perspectives on the influence of social determinants on Women's health

The study participants shared their views on the influence of factors like education, living, and working conditions in relation to their health. Some probing questions, e.g., what made you think so? Why did you think so? , were used to extract more in-depth information.

Subtheme 2.1: Socioeconomic conditions

Most of the women thought that money played a vital role while seeking healthcare. Women revealed that weaker socioeconomic status further reduced their accessibility. Many women revealed that they needed to postpone their decisions to go for treatment due to the shortage of money.

P10: We do not have sufficient money. Therefore, we cannot afford treatment. Need to defer things. Then we borrow, postpone this for next year or manage with lesser medicines. I have done these many times for myself.

Subtheme 2.2: Education

Most of the women were either less educated or left school early. The majority of women said that family members arranged a marriage for them as soon as they completed the high or secondary education. Most of the times, women believed that they did not have any choice but to obey the elders in the family.

P6: I was engaged, so I had to leave the studies. I listened and obeyed parent's decision. My family members thought that getting married is right for me.

Subtheme 2.3: Gender discrimination and violence

Some of the women described that they occasionally experienced the incidences of bad behaviors or arguments from the opposite gender.

P3: Yes, there is some discrimination. I have to work more than boys do. It is ok to be a woman.

Subtheme 2.4: Working conditions

The majority of women were housewives. They felt that domestic work was very hectic. Women working at home did not have any schedule.

P7: Inside the house, we do not have schedule and time for ourselves. The working season during summer is very hectic here. So, sometimes, I think that having some job is more beneficial to women.

Theme 3 – Barriers that woman face in accessing the healthcare system

Women face barriers both at the personal level and at the community / broader level.

Subtheme 3.1: Barriers at the personal level

Many women avoided going to healthcare facilities, believing that this would bind them for sparing more time for regular follow-ups and compliance, which they thought were time-consuming. Also, spending more on travelling and accessing the healthcare system concerns them.

P1: Sometimes we think that doctors will advise many things, so we avoid going for medical checkups unless in an emergency.

Subtheme 3.2: Barriers at community and broader level

Women believed that taking care of kids was a tough and responsible job. Leaving kids back home was always difficult. The majority of women ended up prioritizing kids and other work over their health.

P15: I do not find time due to my children. If I have to go to the hospital, I cannot leave my children alone What if doctors say that I have to go for further treatment of a big hospital.

Subtheme 3.3: Participation in the decision making

Most of the women expressed that men made most of the decisions in the family. Even husbands or elders in the family decide about when women should go to hospitals.

P10: Elders make most of the decisions. I do not participate. This is not my job. Why should I take part? However, elders mostly do decision-making.

Nearly half of the participants revealed that they obeyed whatever elders decided.

Theme 4–Factors women think could improve their health

Subtheme 4.1: Healthcare system

The majority of women felt that there was a need for hygiene and cleanliness in the streets. There was no proper system of waste disposal. Many women thought that there was no provision of toilets in public places.

P1: I think about cleanliness. Conditions are unhygienic here. Due to open defecation, it is unhygienic.

Discussion

The study findings revealed that women perceive illness as a regular part of growing up and aging. Women adapt to these conditions and continue living with slight physical and mental discomforts that otherwise could be prevented or treated. Therefore, these women would be classified as unhealthy as the World Health Organization has defined health as "a state of complete physical and mental well being".

Family income influenced the extent of healthcare access. Financial constraints forced women to postpone their healthcare in tribal areas. This was also confirmed by Sahoo *et al.* (4) in a cross-sectional study conducted among 300 women participants who have delivered a baby in the past year in two villages of New Delhi, North India. The researchers found that occupation and monthly income of spouses were closely associated with the place of delivery. About 46.7% of participants belonged to lower-middle-class families, and the study showed that the prevalence of home delivery was 37.7%, indicating a direct association of demographics with the choice of place for delivery. Due to lesser control over financial decisions, women were not in a position to decide about spending on health. Davis *et al.* (17) have also supported this evidence in a qualitative study conducted in low-income communities in Mumbai. The study included 66 in-depth interviews and a survey of 260 married women. The researchers found that husbands and other family members perceive women's health as a liability or limiting factor on the family financial resources.

Women thought that health illiteracy detaches them from the healthcare system. Most of the participants admitted that they felt the need for education during the latter part of their lives. This evidence has been supported by the research work of Carollo (18) who found that even in countries like the United States of America, one in every five individuals has health illiteracy. There was a reduced rate of literacy. Halim *et al.* (19) in one study conducted on investment pattern in Indian primary schooling, found that caste, religion, and socioeconomic status influenced the literacy rate. The study used the data from the District Information Survey for Education and Election commission of India for the year 2007-08 that covered 624 districts in all the states and Union Territories of India.

Women in the areas of Udaipur experienced limited cases of domestic violence and discrimination. Ellsberg (20) in his review study on global health crisis about violence against women found that understanding the long-term implications of domestic violence by men helped to ensure women's safety inside and outside homes. In the villages of Udaipur, women have formulated self-help groups for community work and welfare of women. These groups are registered with the local administration and work in conjunction with the welfare department. Women facing problems of discrimination or violence take help from these groups. Therefore, these self-help groups protect women rights and raise their voice.

Working conditions of women influenced their health participation. Women found domestic work hectic and unorganized. Travasso *et al* conducted a qualitative study among 48 low-income working mothers aged between 19 to 40 years in Bangalore, India. The study concluded that women engaged in domestic work did not get leave or free time. Continuous work and taking care of children create anxiety and stress. Women thought that employment with some enumeration could help them in taking better care of health.

Chiang *et al.* (21) have concluded a similar kind of evidence in a cross-sectional study conducted in rural southern Egypt. The study was conducted among 205 women participants recruited by the method of stratified sampling from three purposively selected villages with a total population of 50,000. The researchers recognized structural, financial, and cultural barriers to healthcare access by women. About 30% of the women found distance and transportation as the structural barriers while, for 42% of the women, money was a barrier. One in every four women found power and poor decision making as a significant barrier of healthcare access. Due to poor health, literacy, and high out of pocket spending, women in India do not access maternal health care services to the full potential.

Women in the current study revealed that poor quality of health services limit their tendency to go for institutional deliveries and preventive checkups. This can be compared to a study conducted by Okonofua *et al.* (22) in Nigeria. The researchers conducted a study in eight secondary and tertiary hospitals in four out of six geopolitical zones of Nigeria. The qualitative study included focus-group discussion with 40 women attending antenatal and post-natal clinics. They found that Nigerian women were reluctant to make use of maternal health services due to substandard qualities of health services. The long queues, inadequate human resources, and poor trust building by the health care providers discouraged women from going to healthcare facilities.

In the current study, women felt that besides clinical services, the local authorities need to take appropriate measures to improve public health in general. Women expressed that the factors like quality of healthcare, insurance

coverage, and basic infrastructure can be identified and addressed. Quick *et al.* (23) in 2014 studied inequalities in women's health in poor and developing countries. The study supports the findings of the current study by recognizing the unequal access to healthcare, substandard health services, financial, and social barriers as the prime determinants of women's health. The researchers have acknowledged the role of universal health coverage (UHC) in addressing health inequalities and promote women's health globally.

Rigour of the study

Rigour of the research process was enhanced by continuously discussing the work with the dissertation advisor and seeking constructive feedback (24). Sufficient measures and strategies were employed to strengthen the trustworthiness of the research. The credibility of the study was enhanced by conducting the semi-structured interviews in a familiar setting. Dependability of the data was increased by audio taping the interviews with the help of a recording device. Transferability of the study was ensured by providing a full description of the research process, collecting data on the demographics of the participants, and describing study settings. However, the generalizability is not the criteria for a qualitative study but mentioned measures had strengthened the transparency of the research. Researcher's reflection and self-awareness of the positionality enhanced the confirmability of the study.

Limitations

Low sample size of the study was one of the limitations. Some additional time could have been spent on recruitment to include a maximum variation sample. Interviews could have been conducted in different seasons to record the first-hand experiences of the participants, especially during winters and snowfall. Some of the other stakeholders, like health professionals and administrative officers of the area, could have been included as study subjects for broader perspectives.

Recommendations

Based on the findings the current study has proposed possible interventions, as listed below;

- The state government and local administration should make healthy public policy giving due consideration to health in every policy and program.
- The study recommends the need for promoting education since early childhood. Many of the participants left education at a higher or secondary level due to limited prospects. Providing better access to education and career counseling could empower girls for a better future.
- The villages of Udaipur have powerful self-help groups of women. Economic strengthening of these groups could promote women empowerment as they may start some business activities like handicrafts, shops, and woolen clothing, which would give them financial freedom and autonomy.
- At the community level, doctors and paramedical staff should make a proactive approach to reach women and build rapport through supportive and positive communication. The provision of female doctors and nurses should be made so that rural village women could confide in them and discuss their health problems openly.
- Women from the tribal areas should be given exposure by making them visit health workshops, seminars, and camps within and outside the state, and leaders for further training should be prepared.

Future research

There is a lack of sufficient data on how women interact and relate to the social determinants of health. The customized

research, keeping in view the geographical and environmental conditions of Trans-Himalayan regions, could generate more data on women's health. Also, some studies are required on the evaluation of the impact of ongoing health programs to identify the gaps.

Conclusion

This qualitative research study identified poverty, low education, less power, and poor decision making as the significant social determinants that affect women's health. Weak socioeconomic conditions, low education, and less power negatively influence women's health empowerment. Women still are stigmatized and avoid going to hospitals for deliveries. Women of the Udaipur area admitted that poor health literacy and lack of necessary health infrastructure had reduced their trust in the healthcare system. The study has emphasized the need for early involvement of women as a stakeholder of health promotion. Improving the education, financial status of women, and health infrastructure can improve women's health significantly. Healthcare professionals through participatory approach may educate and empower women to make decisions related to their health. The qualitative design and social constructivism approach explored how social beliefs and perceptions shape up the meaning, which women subjectively attach to various determinants of their health. Thematic content analysis approach helped in drawing the inferences and opinions. However, the study could only be transferred to similar settings, and purposive sampling did not truly represent the study population.

Competing Interests

I as author declare that I have no potential competing interests.

Acknowledgements

I as principal investigator would like to thank all the participants for their support and active participation in the study. Further I extend my sincere thanks to University of Liverpool, research guides and my parent department for providing the guidance and support to the study.

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