Social Determinants of Health in Nepal: Some Ethnographic Reflections

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Abstract

Despite its ubiquitous desirability, differences and discrepancies prevail in health. Dissimilarity and inconsistency in health is largely shaped by social determinants of health. Variations in the situation of health are influenced by societal structure or due to the differential experience in life course of people. This paper approaches social determinant as more than limited to fixed categories and rather as a dynamic process mainly because of the fluidity of structural factors. Unequal access to social and economic resources leads to health inequalities. Therefore, this approach regards health as socially constructed phenomenon but not the outcome of mere physical and pathological situation. Engaging with ethnographic evidences acquired from more than a decade of selected studies, this paper portrays how women’s health in different circumstances is socially shaped in Nepali society. This paper urges the anthropologists not be aloof but to engage in examining health development policies and upliftment of health and wellbeing of people at the margin.

Keywords: social factors, health inequality, intersectionality, medical anthropology, Nepal

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1. Introduction

The Constitution of the World Health Organization (WHO, 1946) reflects the Organization's founders’ intention to address the social roots of health problems. It identifies the Organization's goal as “the attainment by all people of the highest possible level” of a state of complete physical, mental, and social well-being. Social and environmental factors that decisively influence public health have been recognized since ancient times, e.g., the sanitary campaigns of the 19th century, and much of the work of the founding fathers of modern public health echoed awareness of the strong relationship between people's societal position, their living conditions, and their health outcomes. Beyond this, we can easily link the ideas that encompass social structures and affect people’s well-being, moving up to Marx and Durkheim.

The post-1950 era witnessed a different epoch in which the social determinants of health (SDH) were shadowed mainly due to an approach based more on health technologies. This was visible in the health systems established in Africa and Asia colonized by European powers catered almost exclusively to colonizing elites and focused on high-technology curative care in a handful of urban hospitals. In doing so, very little attention was paid to broader public health and few services were arranged for people living in slums or rural areas. Despite the post-independence rhetorical claim of extending health care services to rural and destitute groups, in reality, urban-based curative care was perpetuated by the majority of national governmental and international donor-funded programs. The Alma-Ata Declaration (1978) contributed immensely to crystallising the “Health for All” movement. The adoption of the health for all and primary health care strategy manifested a re-emergence of social determinants as a major public health concern. The failure of medical and public health models from around the world in particular to deal with the needs of the poor, makes the concerned stakeholders look for alternatives to vertical approaches. Consequently, community-based approaches began to emerge (WHO, 2005) to address the needs of poor and disadvantaged.

Failure of medical/public health models from around the world to deal with the needs of the poor compelled the concerned stakeholders to look for alternatives to vertical approaches. A WHO position paper in the World Summit for Social Development in Copenhagen (1995) reflected the realization that inequities bring severe health consequences and thus argued that efforts to promote economic growth should accompany more equitable access to the benefits of development. The 1990s era became dominated by the liberalization and market economy approach. However, the limitations of this approach compelled the actors in the field of health development to reflect on the shortcomings and by doing this concern for social development began to come to the forefront.

The early pioneers in the pitch of the SDH, Wilkinson and Marmot (2003), have distinguished people’s lifestyles and the conditions in which they live and work critically influence their health. It is not that poor material circumstances are harmful to health rather the associated social meaning exerts harm. They have identified ten factors as detrimental social determinants to health – the social gradient of being in the lower strata of the hierarchy, the stressful circumstances, early life situation, social exclusion and relative deprivation, workplace stress, unemployment, addiction, food, healthy transport, and social support. Reminding people about its significance, Marmot (2010) takes the SDH as “causes of the causes”, which resides in the social and economic arrangements of society.
Without dismissing the importance of biology, the SDH approach places a priority on the dynamic and convoluted role of non-biological factors in the genesis of illness and early mortality (Burbank, 2011). This method looks at disparities and variations in health. These differences may arise as a result of the social structure or lifestyle choices of the populace. Link and Phelan (2010) raise an objection concerning the focus on personal risk factors for major diseases in the United States and emphasize the importance of societal settings. The comment by Rasanathan et al. (2011) might be interpreted as a summary of it, as it covers people’s living conditions within the framework of social dynamics, as well as their access to resources, money, and power. Health disparities are caused by unequal access to this social and economic wealth. Nonetheless, there is hope because these socially constructed disparities can be prevented and recreated through social structures and interactions.

Anthropologists have shown their reluctance to wholeheartedly adopt this framework as their own (Yates-Doerr, 2020). The constant debate on whether social determinants can be reduced to such disconnected and easily categorized variables without paying attention to social nature of people’s life and factors are externally affecting them. Realizing such shortcomings, medical anthropologists have begun to propose constructive critique to elevate the implications and debate surrounding the notion of the SDH. Arguments of Chenhall and Senior (2018) can be taken as representative in this line of thought which points to the need of theorization and investigation of how broader structural factors exert effects on local places, on individual bodies or over the group of bodies. Moreover, they add that these relationships are not “fixed and deterministic” rather “fluid, something fragile and transformative nature”.

This paper approaches the SDH as a dynamic process mainly because of the structural factors primarily power, access to resources, and access to social and cultural capital, which have never been static over the period. Based on ethnographic information generated from four different anthropological studies, this paper portrays how women's health in varied contexts in Nepali society are shaped by intersections of variety of social forces.

2. **Research Questions and Objectives**

The primary research question this paper delves into is whether and how social conditions and forces shape the vulnerability of people to problematic health situations. If yes, does it affect each segment of society universally, or do they have differential impacts upon diverse segments of society? Engaging with these questions, this paper interrogates the exclusivity of the biopathological approach in looking at health vulnerability through its emphasis on the socialness as root cause of vulnerable and problematic health conditions.

Taking these overarching questions into consideration, this paper has certain specific objectives – to assess how far the health conditions of select groups of people (e.g., women suffering from pelvic organ prolapse, people affected by gender-based violence during conflict and transition period, and Maithil Brahmin women) have been influenced heavily by the social factors in Nepal. The second objective to engage with is whether such factors equally affect the health situation of different groups of people or it differs as per the location of the people in the social matrix and the social and cultural context in which people live. Finally, though the scientific implications of these empirical studies have been drawn from the typical social and cultural context of Nepal, it engages with how far these factors weigh upon the health vulnerability of people from other low and middle-income countries (LMICs) across the globe.
3. Research Methods

This study is developed based on five different empirical ethnographic studies that I have conducted in various parts of Nepal. Health and wellbeing of displaced war widows residing in Kathmandu Valley, women having pelvic organ prolapse from different hilly regions in the central hills of Nepal, victims of gender based violence (GBV) during conflict and transition period and their psycho-social wellbeing and health seeking practices of Maithil Brahmin women from southern part of Nepal have been the sources of empirical data for the development of this paper. Amidst the diversity of study period, site of field study and diversity in social and cultural practices of research participants in these studies, some of the strategies and author’s overall approach to comprehend the health and wellbeing was the common denominator in these studies.

Comprehension of the social determinants of health is intrinsically embedded with social intricacies. Bandyopadhyay (2011) rightly argues that quantitative perspectives are often not useful in this regard. Understanding the social determinants of health also aligns with the advocacy by Bandyopadhyay (2011), the well-designed and well-conducted ethnographic studies. For that, in line with the suggestion of Burbank (2011), community-based study has been adopted for the understanding of the linkages between health and social forces. In these studies, an adequate attention was paid to people’s aspirations, individual circumstances, and experiences in addition to comprehending the way these individuals interact to acquire the available services and the barriers they may face in this course.

The author’s involvement in those studies was as a principal investigator or the thematic team leader of the qualitative aspect of the study which employed a mixed method approach. The involvement was to design, formulate and facilitate to execute the main strategies of information generation, which included observation, participation and interaction, in-depth unstructured interviews, discussions in (natural) groups, key informant interviews and case studies. This paper uses only the qualitative and/or ethnographic genre of the data from these studies. Thematic analysis has been used to make sense of the raw data and make the data speak for the paper. It is obvious to note that the themes were influenced by the overall guiding perspective of the paper, the social determinants of health. Throughout each of the above-mentioned studies and while formulating this paper, the author complied with the esteem ethical considerations of privacy, anonymity, and dignity of the research participants. The ethical approvals for the studies were obtained separately for each of the studies from concerned institutions including Tribhuvan University.

4. Vulnerable Groups

The SDH advocates have been portraying some groups of people as vulnerable to ill-health and health problems due to their living conditions and lifestyle. Blas and Kurup (2010) note that cumulative disadvantage may increase the vulnerability of populations of low socioeconomic status. These groups consist of people from different walks of social life such as slum dwellers, the homeless, migrants, drug abusers, prisoners, and people living with HIV. They also included female-headed households into this category, due to higher rates of poverty, lack of economic opportunities, and social marginalization among them. Ingleby (2012) analyzed various documents to make his opinion about the vulnerable group. He is not satisfied with the practice of labeling vulnerable status to particular groups such as children, elders and people suffering from obesity and physical or people having mental disabilities. Instead, he would like to include the migrants or ethnic minorities as the vulnerable groups.
Regardless of who is vulnerable, some literature suggests that the detrimental impact of SDH makes people vulnerable towards a wide range of conditions including infections, diabetes, high blood pressure, heart attack, stroke, depression and aggression (Wilkinson and Marmot, 2003). On the other hand, delegates of the Rio Political Declaration (2011) consider that vulnerability emerges because people are born, grow, live, work and age in certain situations. They emphasized that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies.

Through engagements with empirical research in the field of medical anthropology, the author has realized that simple labeling of vulnerable status to any group or collectivity is full of flaws. First, it makes them further vulnerable to stigmatization. Such portrayal consequently naturalizes their vulnerability. Secondly, often the vulnerability is labeled on the basis of reducing their identity narrowly to one or few dimensions, ignoring the other crucial aspects of their life, e.g., in my conversation with some war widows in Nepal expressing their dissatisfaction that people merely consider them as widow but not as a human being. Consequently, the third aspect of the flaws lies in ignoring the significance of intersectionality of social and everyday life of people and simply giving excessive importance to one or few dimension of their life. The following empirical cases from Nepali context shows the embeddedness of people’s life in web of social relationships and the imperative of intersectionality to approach them comprehensively.

5. Illustrative Empirical Cases from Nepali Context

Taking the help of five different studies, I would like to show how social forces contribute in shaping the detrimental health situation of people living in the margin of the society. Maithil Brahmin women’s typical social condition, women experiencing uterine prolapse, gender-based violence (GBV) during conflict and transition period, and health and psychosocial implications of armed conflict on displaced war widows have been presented here thinking that they perfectly exemplify the influence of social determinants of health in Nepal.

5.1 Social and Health Situation of Maithil Brahmin Women

Different dimensions of social and cultural factors affect the women’s vulnerability to problematic health situation and their access to health care services among the Maithili Brahmin women from the Lakhanpur area in Nepal’s Terai. Maithil Brahmin women living in the southern plain area of Nepal follow the strict gendered norms and values in their everyday life in their process of becoming bonafide women (Dahal, 2018). The ethnographic fieldworks in both the community and at the health facility were conducted mainly during 2012 to 2015 and the follow up studies then after. Not only was their health condition is shaped by the gendered relation but also that of their access to health care services and their interactions with the service providers is largely influenced by the prevailing gender relation in the locality.

It is crucial to note that health workers in the local health facility have observed that most of the women visit their health facilities with problems what they would regard as somatic. In which women come for a certain health complaints but their initial diagnosis does not consider

1 A pseudonym given to the field site considering the sensitivity of the study.
them as disease. This kind of tiny incidents of *man kharab hune*, the feeling of illness, as the service providers consider, occurs not always in a genuine way. They think that women devise such strategies to get rid of their everyday annoyances in the family and make polite escape. Why these kinds of weapons of the weak (Scott, 1985) are practiced in the locality is obvious in these women’s oppressive social circumstances. Such labeling towards the health seeking women also reflects gendered attitude of the male health workers towards the women in the locality.

The typical social and cultural context in which these women live creates their vulnerability to ailments. That is why women consider that their body is weaker than the male body which frequently invites ailments. The burden of work vis-à-vis their lower hand in the intra-household power dynamics among the family members not only increases their vulnerability for further ailments but also curtails their access to quality health care services.

This study reveals that there is an abundant practice of biomedicine in a localized form. It is embedded in the local social and cultural sphere in different ways; restriction on women’s mobility, and gendered hierarchy and authoritarian patriarchal normative practice and ideas are echoed in these women’s healing journey and also in their interactions with the service providers. While looking at the context of biomedical healing of Maithili Brahmin women from Nepal’s Terai, it is far from being adept to make diagnosis and offer treatment of the problematic health situation of women being objective and value neutral exclusively depending upon their bio-pathological situation (Dahal, 2022). Health facilities in the locality mirror and strengthen the overriding social and cultural processes of society.

5.2 Women with Pelvic Organ Prolapse

I was surprised when I hear for the first time from a Dutch gynecologist Dr. Loes Harmsen that she met an elderly Tamang lady in Kabhre district that she had been living with the condition which physicians and gynecologists consider as having pelvic organ prolapse. In our subsequent field research, we managed to meet the lady at her house. I talked to her husband whereas a female field researcher accompanying with me met her and held a long conversation about her life, health and ailments. To our surprise, the lady no longer considered this prolapsed condition of her uterine as a disease. She had taken it as a condition that develops along with the child birth, usually after the first pregnancy. She acquired such knowledge from her elder sisters and mothers. The lady kept on enduring this condition for about four decades. She has had four other successful deliveries. That condition did not have any remarkable impacts on her conjugal life as well. In her old age, only when she went to the Dhulikhel Hospital when there was a free gynecological check-up camp, she got to know that she was living with a deadly disease for such a long time.

The studies based on which this part of the paper is being developed were conducted in different parts of the middle hills of Nepal, which have steep terrain where these women have to tread up and down to meet their daily needs. The field sites were particularly in Dhading, Gorkha, Kabhre, Sindhupalchowk, and Parbat districts. The studies were conducted among the women having uterine prolapse, and thus they were not focused on any distinct caste or ethnic group.

Women’s vulnerability to uterine prolapse in these locations ranges in different dimensions. Early and unequal marriage with the aged man, unsafe sexual practices immediate
after the child birth, excessive child bearings, unfavorable familial situation for the women, inadequate pregnancy delivery and post-delivery care, smoking, work burden are some of the social factors that have detrimental effects on women pelvic health situation. The steep geographical terrain in which they have to carry heavy loads everyday further increases their vulnerability (Dahal, 2017). The impact of the disease is not confined merely to the body of the women; it affects her family and spouse relation as well.

I would like to borrow the wisdom from a behavioral and psychological study which shows that gender differences typically emerge in the measurement of social support, with women frequently reporting more social contacts and greater satisfaction with relationships than men (e.g., Vaananen, Buunk, Kivimäki, Pentti, and Vahtera, 2005). This typically resembles the information I have acquired in my conversations with the women having uterine prolapse that their main expectation immediate before the surgery was not the recovery from the ailment rather to be able to take care of family members, mainly the younger children.

5.3 Gender Based Violence during Conflict and Transition Period

The author was involved as a research coordinator in exploring the gender based violence (GBV) during conflict and transition period. This mixed method study was conducted during 2010-2011 period in select districts of Nepal covering each of Himalayan, Hill and Terai regions of Nepal. The field sites included ten selected districts in Nepal’s Terai region – Kailali, Dang, Banke, Rautahat, Bara, Sarlahi, Mahotttari, Siraha, Dhanusha, and Morang. Based on the consultations at the district level key informants, 40 wards from 20 Village Development Committees (VDCs) from these districts were selected based on high prevalence of conflict and transition era GBV victims. Physical assault, murder, missing/kidnapping, threat/fear, rape, suicide, allegations of witchcraft, and trafficking are main forms of violence that had escalated the suffering of the victims and their family members (NCCR, 2011). The study also showed that women and girls as well as men and boys became the victims of targeted assault; however, girls and women suffer much.

Men and women suffer from different forms of violence, e.g., physical violence is enacted to weaken men and sexual exploitation of the women and girls as a means to take away family honor. Women’s bodies became battle ground over which opposing forces, the security forces of the government of Nepal and the Maoist, fought each other when we look at the cases of rape during this conflict. Rape was used as a “weapon of war” during conflict, leaving mental, physical, and social scar on the victim themselves. Not only the rape, but any of the single episode of violence led to the series of violence in the life situation of the victims.

Various forms of psycho-social impacts unfolded into the life of conflict era victims. The body politic (Schepers-Hughes and Lock, 1987) exercised by the two opposing forces constantly created the feeling of unsecured among the parents and their children, which was also accompanied with the lowered self-esteem. Clearly visible differential impacts among the psycho-social and behavioral health of boys and girls was that there was increasing trend of aggression and drug addiction among the boys whereas girls were found to have been deeply disturbed from inside.

Most of the rape victims were suffering from embarrassments, shame and guilt. The depression and anxiety level heightened among themselves. Some of them were feeling isolated
even from the family and the relatives though they knew that it was not their fault. Some of the rape survivors also stated that the suicidal thoughts frequently came into their mind.

5.4 Health and Psycho-Social Well-being of Displaced War Widows

Compared to physical health, psychosocial health is more susceptible to social factors. Emile Durkheim (1951) identified the importance of social circumstances as a factor influencing suicide rates as early as 1897. Ten years long armed conflict led by the Communist Party of Nepal (Maoist) in Nepal was ended in 2006. This part of the paper is also based on the primary qualitative information acquired from an ethnographic study which was conducted in that very year when the government and the rival factions were signing the peace agreement. This conflict provided a “risk factor” (Shim et al. 2015) which preceded several negative consequences including the troubling psycho-social health of displaced war widows in Nepal. The ethnographic study indicates that the degree of their suffering either began there or was made worse by these circumstances, even though conflict and the ensuing relocation are not necessarily the direct causes of suffering (Dahal, 2010).

Some of the powerful social factors get onset due to the decade long armed conflict, e.g., displacement from their home, property, locality, as well as social and cultural network and context. Women lost their husband and they got the stigmatized status of widow on top of losing their life partner and breadwinner of the family. Displacement made them deprived of using their own social, economic, and cultural resources. They were compelled to live in unwanted circumstances in new location and deprived situation. Some of them were also blamed for the untimed and thus bad death of their husband, taking their misfortune as the main culprit behind his unnatural and bad death. With the loss of breadwinner, weakened social connectedness, and additional work burden, many widowed women found themselves in the situation of helpless and thus were in the state of hopelessness about the current and future path of their kids and for themselves.

Social suffering of these women operates, as articulated by Kleinman, Das, and Lock (1996), in vicious spiral of political violence, forced uprooting, displacement, and profound trauma to the individual and family in addition to escalating domestic abuse and personal suffering. That may even expand up to a bureaucratic backdrop of health and social welfare. This trajectory led to the emergence of various forms of psychosocial problems which included sleeplessness, declining social connectedness, suspicion and worries, increased tension, and irritation. In this way, conflict era victims’ bodies have ‘articulated the grief through their body’ (Das, 1996, pp. 68) and that was also mediated by the prevailing gender ideology.

Research in epidemiology, behavioral medicine, and health psychology has indicated that recipients of social support live longer, develop fewer diseases, and recover easily and faster from illness (Cohen, 2004). Social support contributes to a lowered stress-induced psychophysiological reaction. It is important to keep in mind that social support is a socially mediated phenomenon rather than a neutral resource that anyone can access when they need it. Displaced war widows in Nepal experienced exactly the opposite of what Vaananen and colleagues (2005) had claimed because of the negative social attitudes toward bereaved women, who are often even held responsible for the death of their spouse.
6. Addressing Social Determinants of Health: Imperative for Developing Countries

The social determinants affect health conditions of people everywhere, though not in a fixed pattern. Denton, Prus and Waltors (2004) analyzed the data concerning factors determining gender and health in Canadian context. These scholars had come up with the findings that social structural and psychosocial determinants of health are generally more important for women than their male counterparts. The primacy of availability and access to material resources among the social determinants escalates the misery of large number of people, living in the absolute poverty level accompanied with huge gap between the rich and poor people, in the low and middle income countries.

Equally important is the situation of gap of resource allocations at the world scale depriving many countries in the peripheral Global South. Therefore, “the unequal distribution of health-damaging experiences” is not a “natural” phenomenon from any angle. Rather, it is resultant effects of a lethal blending of inappropriate social policies and programs, unjust economic measures, and wicked politics. The structural determinants and conditions of daily life collectively create the social determinants of health, which are primarily liable for health inequities within the country as well as at the international level (CSDH, 2008, pp. 1). In this context, the SDH approach concerns for justice and equality in health and healthcare.

In the 1970s and 1980s, “the global health for all” approach placed a strong emphasis on the necessity of addressing social factors (WHO, 2005). Up until now, nevertheless, these suggestions had hardly ever been turned into practical legislation. In light of this, several heads of state, health ministers, and government delegates have made commitments to the SDH in the Rio Political Declaration (WHO, 2011). Actually, it has brought attention to how important it is to address the socioeconomic determinants of health. Absence of national policies calls into question the welfare and development initiatives made by individual countries as well as by UN agencies like the WHO.

In order to deal with the SDH phenomenon, the WHO (2005) laid out four key points along the “social production chain” in which policymakers can step in to design their policies. These include reducing social stratification itself, lowering the specific exposure of those in disadvantaged positions to elements that can harm their health, lowering the vulnerability of those in disadvantaged positions to conditions that can harm their health, and stepping up in healthcare to lessen the sloppy effects of health problems and prevent their further socioeconomic degradation. The WHO's proposal appears to be quite thorough, and it is believed that this is precisely the root of the issue.

7. Conclusion and Recommendations for Further Actions

The SDH approach clearly and firmly acknowledges the social nature of detrimental forces on health in the context of dominating bio-pathological approach. This lens has been able to reflect and establish the knowledge that unequal access into social and economic resources leads to health inequalities. The factors simply construe the condition; therefore, the point of caution that is emphasized here is that instead of focusing on the mere factors of social determinants, our focus has to be directed towards the way individuals feel and experience them, which eventually influences and makes differences in people’s health situation. Ethnography equips us, as Chenhall and Senior (2018) articulate, to grasp not only the patterns of belief and
experience in communities but also individual differences within them, as well as subtle and dramatic alterations taking place in these realms as per the changing circumstances.

The empirical cases from Nepal equips us to firmly argue that rather than a single or a bunch of factors, the intersectionality of factors leads to inequality, deprivation, and unwanted situation in societal realm for the people at the margin of the society. These ethnographic materials also suggest that to make strong statements on the issues of the SDH it is imperative to navigate through the nuances and subtleties of everyday life of common people, often the people at the societal edge.

As the detrimental factors are intersectional, vertical approach, forget about the singular “capsular promise” (Harper, 2014), is insufficient to address the health concerns. There is a need of integrative perspectives to look at causes of health inadequacy and inequity, without which it is difficult to identify dysfunction, pathology, and injustice. However, the silver line on the horizon is that these inequalities are socially construed through the social systems and social relation, and thus are avoidable and regenerative socially. To reduce health inequality and promote public health, government policies and practices in the low and middle income countries have to pay adequate attention to various factors of social determinants of health and focus on health promotion rather than simply on the curative medical approach. For that, they can adopt the practice on continual systematic research to know about the intersectionality and dynamic social realities affecting health and wellbeing of people. Such evidence will support the government and other actors involved in Nepal’s healthcare development to address the pressing concerns and factors affecting the health of women and other vulnerable populations.

Ethnographers involved in doing research in health care domain need to give voice to the sunk, patchy, and quiet subcultures of the sick. They can give voice not only in academic platforms but also through other means of mass communication. Good policies could be a starting point but not adequate. Therefore, anthropologists have to look at the social context of health policy formulation, actors involved in the process, and the negotiation and dynamism embedded in implementing these policies into practices. They should not be aloof to the detrimental health conditions of people at the margin. In agreement with Schepfer-Hughes (1990), when she portrays that even Malinowski referred to anthropology as a vocation with “specific moral obligation” to have applied significance of his/her knowledge to the people working with. Therefore, it is imperative that anthropological studies can and should be directed to grasp the pattern of ideas and practices on problematic health conditions and their social and cultural situatedness aiming to ameliorate the situation of the people undergoing through such circumstances.

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