Women as Co-Creators of Health

An Ethnographic Study of Measures to Meet Health Needs in Rural India

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Kvinnor som medskapare av hälsa – en etnografisk studie av hälsostödjande insatser på Indiska landsbygden

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Abstract
Health as a concept encompasses every aspect of life, not merely our physiological functions. Even so, the global efforts on women’s health, both within the research and aid field, have a history of being reduced to reproductive health alone. The aim of this study was to look at the pre-existing health needs of women in rural India and also to investigate how increased knowledge is used as a tool for creating positive conditions for supporting health in congruence with their needs. The study was conducted using an ethnographic design and the context was an educational Institute for rural and tribal women in Indore, India. The study showed that having no access to education, information or frames of reference, individuals are unable to identify their own health needs and unlikely to question traditional practices or value systems however harmful they might be. Not until fundamental needs are met and skills such as literacy, numeracy and empowerment are implemented is health education likely to have any lasting impact on a population. Previous studies on health literacy have shown the interconnectedness of these individual skills and capacities and the health status of that same population.

Keywords: Women’s health, holistic, rural India, health literacy, ethnography, support health, education
The focus of this study is to describe and understand health needs of women in rural India. To develop an understanding in collaboration with the participants of how health can be supported among women and what role access to knowledge and information plays in that process. The study is conducted using ethnographic methodology and the ambition is to draw a rich picture of rural women in India as co-creators of knowledge concerning health. In order to achieve this aim the approach has been promotive, explorative and participating.

According to Pender, Murdaugh and Parsons (2006) mankind needs to be recognized as a global community as well as a health mega-system since one country’s health effects are not isolated occurrences but has an impact on other nations as well. Just as the wellness of a society largely depends on the establishment of policies that protect health for all groups, individuals have a most important role in determining their own health status. Working as health promoters, nurses need to take place in the forefront of developing interactive health education in programs and interventions in a global setting.

This study is focusing on a non-profit organization in Indore, India, that has realized the significance of a holistic approach to health and the importance of raising capacities in women in order to improve their health. The organization is working preventatively through education, training and empowerment of rural and tribal women.

Background

When defining health as a concept one frequently encounters the description by the World Health Organization [WHO] from 1946, which states that health cannot be seen as merely the absence of physical illness, but rather consists of a wellbeing expanding over three main components; physical, mental and social. Other humanistic approaches to health in nursing and caring science include Dahlberg and Segesten (2010) who argues that health is a state of balance effecting ones entire being. It is both an inner balance as well as a harmony extending to ones relations to fellow humans as well as life in general. Erikson (1994) also offers a view on health were body, soul and spirit are depicted as inseparable components of human beings, where all parts need to be integrated in a state of soundness and well-being for health to be experienced. Dahlberg and Segesten (2010), Eriksson (1994) and Toombs (1993) argue that
health consists of several dimensions and is dynamic. That health and suffering are not
dichotomies, but on the contrary, can co-exist provided the suffering is bearable, and thus
making it possible to experience health even when afflicted by disease. Health is consequently
highly individual, dynamic and influenced by several internal and external factors. While
disease-free we rarely ponder upon our health status. Not until we encounter illness do we
become aware of our degree of health (Gadamer, 2003). Along the same humanistic lines
Maslow (1943) also indicates that although struck by illness we would not naturally
contemplate our state of health depending upon what stage in the hierarchy of needs we
currently find ourselves. At the bottom of the hierarchy, where a vast majority of the
population in the developing world is presently situated, man’s mind is occupied with the
basic physiological needs such as access to food, water, shelter and rest. Before being able to
transcend to higher stages in the hierarchy it is not likely for people to be aware of a broader,
more comprehensive sense of health, nor discover their own needs or how to accommodate
them.

These holistic approaches to health reflect the dynamism and complexity of the concept. In
accordance to humanistic standpoints it would be imperative to take a broad spectrum of
essential components such as social status, access to education, opportunities for individual
development etcetera into account when striving to improve and support health in a
population. WHO (2013) attributes women’s poor health status in developing countries to
several social factors such as gender inequality, limited opportunity for education and
employment, the focus on women mainly as reproductive beings and different levels of
violence acted out towards this group. WHO (2013) also points out that although poverty has
a negative effect on the general health of both genders, women tend to be affected to a higher
degree due to inequality and practices prescribed to gender roles.

**Women’s health from a global perspective**

When searching for international research on women’s health from a global perspective there
is very little to be found that touch on the subject as a whole. Already in 1997, Meleis and Aly
(1997) pointed out in their study on women’s health globally, that one concern is the trend for
research carried out on women’s health to have a focus on their reproductive role alone. When
reviewing current research it seems evident that this particular type of reductionist or
biomedical approach has been preferred when dealing with health issues amongst women in the developing world. Through compartmentalization of women’s lives and reducing women’s health to concern only the reproductive spectra simplifies the issue of health and invites to quick-fixes and short term solutions. In order to make a lasting improvement in the health of a population it is necessary to look at all surrounding aspects of the individual’s life. Meleis and Aly (1997) pose strong criticism towards reducing women’s lives to reproduction and calls out for top priority for research on women’s situation and daily lives from their own perspectives with the purpose to integrate that knowledge into health care plans. Further on Meleis and Aly (1997) also describe the need for strategies that empower women, describing empowerment as a holistic approach for improvement of women’s health through providing them with necessary tools to alter several aspects of their own existence.

Looking at the current situation in health research the criticism by Meleis and Aly still seem valid. Bustreo, Knaul, Bhadelia, Beard and Araujo (2012) also highlight the tendency to equate women’s health with reproductive health and therefore directing both resources and attention from a holistic viewpoint to concentrating on maternal health alone. Bustreo et al. (2012) further describe how, although women in general have a longer life expectancy, they are subjected to poorer health throughout their life span. The authors go on to call for both policies and programs that have a holistic view on women’s health to provide them with adequate support to change their health situation. Bustreo et al. (2012) also welcome more research on women’s health in developing countries that explore health in the light of gender inequalities and social factors.

**Women’s situation in Madhya Pradesh, India**

This study took place in Madhya Pradesh [MP], the second largest state in India that has, with its 72 million inhabitants, one of the highest populations in the country. According to the national survey Census 2011, MP is an agricultural state with over 72% of its population being rural or tribal. Statistics from the region draw a picture of the situation for women in MP to be harsher than for the average Indian woman. The numbers show challenges such as lower literacy rate, lower life expectancy, higher child mortality rates and larger sex ratio than the country’s average. According to the latest numbers from the National Crime Records Bureau (2012) MP is exhibiting noticeably high numbers for all crimes against women, scoring highest statistics in the country in areas of rape, molestation and importation of girls
(due to the lack of women, girls are bought as brides from other states), while also ranking high in the number of other crimes against women such as kidnappings, dowry death and sexual harassment. Anuradha Shankar, the Inspector-General of police in Indore, the capital of MP, states in an interview in The Hindu daily newspaper (2012, October 24) that the number of rapes are a reflection of the general view on women in the area, namely that girls are considered a liability and that women fill two functions alone; sex and giving birth to boys.

Another challenge faced by the rural inhabitants of MP is the lack of hygiene which is manifest in areas such as no access to clean water, living conditions unfit for humans (and often also shared with animals) as well as unclean and unsafe birth practices (Patil, Sonasundaram & Goyal, 2002). According to India Sanitation Portal (www.indiasanitationportal.org) it is estimated that over 1 million households in MP don’t have access to toilet facilities and that people have to relieve themselves in the open. This was confirmed during interviews for this study, along with the additional information that sanitary conditions in general in the villages of MP are close to none, with no garbage disposal nor proper washing facilities. Having no access to toilet and hygiene facilities is not only a sanitary hazard, but also pose a real safety risk for women (www.indiasanitationportal.org). During the interviews it became apparent that the only opportunity for women to defecate was in the middle of the night when they would have to wake up and go out into the forest to relieve themselves. Considering the unsafe environment for women, this practice poses a real and frequent risk for women to be raped or kidnapped.

Autonomy of the women in rural and tribal MP is strictly limited. Nearly every aspect of their lives from schooling, age of marriage and whom to marry is decided by the parents and once married all important decisions are made by her husband (Singh Rana, 1998). In rural villages parents arrange marriages, often when the girls are still under-aged, but in the tribal areas a girls marriage is not pre-arranged but constitutes of a man kidnapping the woman he wishes to marry. There are no legal documents signed, and so after being kidnapped the woman becomes his property. If the woman wishes to leave her kidnapper, she has great difficulties, and the scenario is likely to end with anything from her family’s bankruptcy to her murder (Singh Rana, 1998).
In response to India’s health challenges

Ever since India’s independence in 1947 and until today’s date, the government of India has been struggling unsuccessfully in providing adequate health services for its own population, especially falling short in terms of reaching the under-privileged rural population which constitutes a majority of the country’s inhabitants (Sharma & Bhatia, 1996, Pati, Sharma, Zodpey, Chauhan & Dobe, 2012). Trying to bridge that gap, over 5000 voluntary organizations have taken it upon them to support and promote health in the country, specifically targeting the scheduled population. In many areas voluntary organizations have reached better results than the government efforts have been able to show forth (Sharma et. al, 1996), but regardless there are still many areas that need improvement. In a Strengths, Weaknesses, Opportunities, and Threats analysis [SWOT] Sharma (2005) point out priority areas for the voluntary organizations in order to obtain a more sustainable solution to India’s growing health needs. Some of the areas mentioned are the need for holistic empowerment both on an individual and community level, the necessity of including traditional knowledge (such as herbal medicine and Ayurveda) when working with community health, the promotion of gender issues and behavioral change in the areas of family planning and hygiene. These ideas are supported by Pati et al. (2012) who additionally calls out for a need not to use health education merely as an information tool, but to design programs that build on people’s capacities and support their own innovative abilities. The importance of involving the community to take ownership of their own development is also stressed by Patil et al. (2002), who suggest community-selected individuals to receive adequate training in order to make the programs integrated on a grass root level.

Purpose

The purpose of this study is to recognize how to create positive conditions for supporting women’s health in congruence with their needs. The goal of the study is to gain knowledge about the pre-existing health needs of women in rural India and to gain a deeper understanding of how the chosen Institute is catering to those needs.

The key questions are:

What are the pre-existing needs of the participating women?

How is the educational program of the Institute answering to those needs?
Method

Study design
This study was conducted using an ethnographic design. Ethnography offers a unique opportunity to explore the field of interest in a more enveloping fashion than most other research methods due to the way it is conducted (Murchison, 2010). In this study the investigator role was an active one with full participation in the institute’s activities and the every-day lives of the women, therefore making the ethnographic approach applicable since it is customary not to take on the role of a by-standing observer, but to engage as an active contributor together with the participants (ibid.).

An ethnographic design is commonly used when aiming for a deeper understanding of the collaborating dynamics that social and cultural elements add to a question (Murchison, 2010). When investigating an arena such as health, which in itself spans over several aspects of existence, the holistic approach of ethnography proves very useful. The experience of health is highly affected by cultural and social elements which can be hard to comprehend or even take note of as a bystander. To then have the opportunity to immerse in the life and daily existence of the women at the Institute provided a unique chance to see nuances and conjunctions on a deeper level than otherwise possible (ibid.).

In accordance with ethnographic procedure, which usually involves the researcher spending a considerable amount of time in a specific setting, observing and participating in the daily life of that context and gathering data through several sources, using him/herself as the main research instrument (cf. Hammersly & Atkinson, 2007, Miles & Huberman, 1994), this study was conducted while living together with the women at the institute and joining the daily activities on equal premises for a duration of two months. Miles and Huberman (1994) also emphasises how the ethnographic study is able to bring forth the complexity of the situation being studied both due to participating in the lives of the participants but also because of the use of multiple methods for collection of data. The different methods used in this study were interviews, conversations and participating observations while field notes were recorded regularly.
Knowing very little of what to expect in terms of the women’s thoughts and ideas about health or their level of knowledge, being placed in the position of a student was inevitable. Entering the field with this mind-set also allowed for being faced with pre-conceived ideas and having to rely on the participating women to take the place of teachers and experts (cf. Murchinson, 2010). Since there was no possibility to gain sufficient background knowledge before entering the field it was necessary to get to know the women, experience their daily life, converse, see their study material and join their classes. Only after doing so was it possible to understand which questions would be relevant in order to achieve the purpose of this study (ibid.).

**Setting and participants**

The chosen institute is a Non-Governmental Organisation [NGO], founded in 1985 with a well-established program for educating and empowering women from social sectors normally restricted or excluded from education such as tribes, scheduled casts and physically challenged women. Since its foundation the Institute has seen approximately 6500 women graduate their courses. The resume of collaborating or sponsoring organizations that the Institute can show forth is ample and includes names like SIDA, UNEP and the Government of India.

The women residing at the Institute during the time of the study were rural or tribal and between the ages of approximately 15-25 (an exact number was not obtainable since some of the girls did not know their own age). At the time of the study there were 83 women from 42 different villages who had all enrolled in the program 3 months previously. The educational program spans over six months, and so the women were at mid-point when the gathering of data was initiated.

The program offered for these women consist of five main fields; *literacy*, which lies as a foundation for the remaining educational program, *development of myself and my community* which is intended to empower the women and build on their material and spiritual capacity, both as individuals and also in relation to their surroundings in order for them to become agents for social change in their home communities upon return. The third field being taught is *vocational skills* such as cutting and tailoring, typing and computer literacy which all hold the potential to make the women financially independent. They also
receive environmental training including organic agriculture, conservation, recycling and use of solar energy. The fifth main field is health education to give the women tools to prevent and recognise illness, prepare home remedies and to identify when professional medical care is necessary.

For the conducted interviews the participants were chosen according to purposive sampling (cf. Polit & Beck, 2008) in collaboration with the executive director at the Institute. Criteria for inclusion were women that had been partaking in the program for a minimum of six months. Exclusion criteria were volunteers at the Institute. The selected women were senior students, meaning that they had been at the Institute between 9-28 months and were chosen due to their familiarity with the health curriculum, while at the same time having arrived recently enough to have a vivid memory of their level of knowledge and behavior upon arrival.

**Data collection**

The data collection took place on site at the chosen Institute in Indore, MP. Participating observations were conducted, conversations held and interviews performed until richness in data had been achieved and all variations of the phenomenon were considered to be gathered (cf. Kvale & Brinkmann, 2009). All forms of data were obtained during the time period of August - October 2013. The interviews were semi structured, qualitative research interviews (ibid.), held in couples with 8 of the senior students and all lasting between 35-70 minutes. The interviews were conducted by the researcher in English and translated by the director due to the existing language barrier. The interviews took place in the director’s office and were recorded digitally and transcribed in immediate connection to the event (cf. Kvale & Brinkman, 2009). The interviews were held with the intention to gain an emic perspective into the women’s needs, to listen to their own expressions and understandings as perceived by someone from that particular socio-cultural background (Holloway & Wheeler, 2002). The aim was also to investigate the emic perspective of how the educational program was catering to their needs. In addition, field-notes were taken regularly, documenting observations, conversations and experiences (ibid.).
Data analysis

All collected data was transcribed and organised in order to get an overview of the material at hand. The procedure for analysis was based on LeCompte and Schensuls (1999) taxonomic analysis steps. After gathering all the collected information it was read repeatedly in order to gain a full sense of the material and to search for patterns and reoccurring themes. To reduce the mass of data obtained during an ethnographic study, the material was broken up into smaller units and given a meaningful label (cf. LeCompte & Schensul, 1999). The units were then compared with the purpose of finding similarities and patterns in order to organize and group together units with similar content. To make sure to maintain the meaning of each unit the original data was constantly revisited. After dividing the material into labelled units it was possible to branch them into two main areas, each representing one of the research questions; what are the pre-existing needs of the participating women and how is the educational program answering to those needs. Under each main area three categories immerged, and in turn several sub-categories. As the case with any ethnographic study, the analysis of the material always involves interpretation and a certain degree of speculation from the researcher since all material is gathered through personal interaction and filtered through the researcher’s eyes (cf. LeCompte & Schensul, 1999). In order to limit speculation and not lose the context of the material, the original data was constantly revisited, and to make sure the analysis was relevant it was weighed against the research questions regularly. In this manner the analysis process was non-linear and all steps were revisited during the procedure to re-evaluate and search for new meanings and connections (ibid.).

Ethical Considerations

When conducting research involving people and their lives it is of utmost importance to follow certain ethical guidelines (Polit & Beck, 2008). Austin (2013) points out that using a qualitative method entails a research-participant relationship which often is an engaged one. In this type of conduct it is important to make the participants feel comfortable and at ease when sharing experiences or being observed in their every-day living.

Since this study involved a setting consisting of 95-300 people both living and visiting the site, and the fact that there would be no opportunity for individuals to choose not to be present at the Institute during the time of data collection, these factors were weighed into a risk/benefit assessment of the study (cf. Polit & Beck, 2008). To be a member of the
observed group would pose minimal risk of any consequence to the individual and in the presented study there would be no possibility for identification of separate individuals or the Institution itself. Due to the overweighing beneficence, such as the excitement of being a part of something different from every-day life, the empowering experience of having someone genuinely interested in getting to know about their lives, thoughts and concerns, and finally the more altruistic benefit of knowing that participation might help others in a similar situation to theirs, and a minimal risk for the individual participants, the decision to let the chief operating officer determine participation was made. After sending a project plan containing the name of the overseeing university, aim of the study, methodology, plan for data collection and expected outcome to the Institute, consent to use it for data collection was acquired (ibid.).

In regards to the individuals chosen for interviews verbal consent to participate was obtained from each one after being presented with verbal and written information on the study. To adhere to full disclosure, the material was presented both in English and Hindi and included aim and expected outcome of the study, name of overseeing university, guarantee of confidentiality, both during the conduction of the study as well as in its final presentation. To ensure confidentiality, no names or other forms of identification were recorded in any of the collected data. In accordance with the principle of human dignity and self-determination, the material presented to the individuals being interviewed also contained information regarding participation being strictly voluntary, informing them of the right to withdraw from the research at any given time (cf. Polit & Beck, 2008). To adhere to the principles of beneficence and justice, care was taken to ensure that the interviews would not cause upset or psychological stress. This was done by allowing a staff member from the same cultural background and with a good relationship to all participants, to go through the intended questions beforehand in order to evaluate their cultural appropriacy.

During the interviews, care was taken to observe the state of the participants in order to be able to take necessary breaks or address something that might have been upsetting. The participants were also informed that they could turn to the researcher or the executive director if they had any questions, both of whom were constantly available on site (cf. Polit
& Beck, 2008). According to Swedish Health Care Act (2003:460), an ethical review was not necessary since the study was conducted on an under graduate level.

Findings

The results are presented in two main areas originating from the research questions. The first one mirroring the pre-existing health needs of the participating women and divided into categories and sub-categories based on the interviews, conversations, observations and field notes. The second main area concerns how the educational program at the Institute is answering to those needs.

The pre-existing needs of the participating women

A new perception of health - a shift in understanding
In regards to the first research question addressing the women’s pre-existing health needs it became evident during the interviews that before arriving at the Institute the women were either partly or fully unaware of any health related questions (some even confessing to never have heard the word health before). With limited or no access to education or information, these women lack a perspective into how their health or living conditions differ from other parts of their country or the rest of the world. Living with restricted access to knowledge and information their own reality was rarely questioned and consequently the women were unaware of even having health-needs (apart from the obvious occurrences of occasional physical ailments). After coming to the Institute and gaining knowledge whilst also experiencing a different reality, their understanding of the concept of health expanded to include several aspects of life and also took form as something that can be affected and improved. After seeing and experiencing an alternative, the women were now able to see their own needs as well as the needs of their fellow sisters, along with the possibilities for improvements present in their home villages.

After being trained at the institute the women’s understanding of health had expanded to encompass the following fields; social environment and surroundings with the emphasis on a
clean environment and the understanding of equality between casts as well as gender. *Physical wellbeing*, containing knowledge about cleanliness, nutrition and treatment of bodily ailments. *Spiritual health* defined as setting aside time for prayer, meditation and yoga in order to reduce stress and gain peace of mind. Through their newly gained knowledge the women were now able to define the areas within health that would need to be addressed in their lives and the lives of their fellow peers.

*Support in their home environment*

The interviewed women expressed concerns in regards to the expected support upon their return. Factors they described as detrimental for women’s health in their villages was the expectation to undertake heavy physical labour, also when ill, having no time for themselves or for rest and recuperation along with a poor nutritional status. The women expressed that after their time at the Institute they now had the knowledge to discern whether a practice is beneficial or not for their health and they were able to make correct choices. With their increased knowledge, skills and self-esteem, all but one of the interviewed women believed that their families would support the changes in health and hygiene that they would bring home with them. This was confirmed by the director who regularly visits former graduates. According to her observations, the health changes is the one field that is readily accepted in the villages, whereas women’s further schooling or using their acquired vocational skills to make an own income meets a much greater resistance. The director estimates that the health curriculum has a lasting influence to some degree on each and every former graduate, 60-70% manage to make a greater amount of changes in their own life and the life of their family while approximately 20% are empowered to such a degree that they make drastic changes and have an impact on the larger community.

*Empowerment for accomplishing lasting changes*

Due to the low status of women in rural MP the changes taking place in the women’s minds and lives at the Institute would not have a lasting impact if the women weren’t empowered during their stay. In order for them to maintain their changes upon return and also to be able to convince their families and friends to accept the newly acquired knowledge and habits, great efforts to develop the women’s character are undertaken by the Institute.
How the educational program is answering to the health needs of the women

At the Institute a thorough health curriculum has been developed with the three following goals; to empower women in such wise that they become resources for change upon return to their villages and to give them a greater understanding for health related issues. To create health awareness in order for the women to maintain their own health and also support others in doing so. To encourage traditional health practices which are safe and recommended by medical staff and to discourage the use of unsafe, harmful and superstitious practices.

Health curriculum

The health curriculum used by the Institute has been developed for almost two decades in collaboration with a vast number of national and international associates from both the health and educational field. The Institute has taken special interest in researching traditional remedies for treatment of common conditions. By learning local practices and consulting medical doctors for expert opinions on the accuracy of the methods and distinguishing which ones might be harmful, the institute hopes to encourage beneficial local practices and simultaneously show how some are based on superstition and should be avoided.

Upon enrolment at the institute the women are divided into groups of 8-9, the groups are composed so that the women from the same village are separated, and every group contains one or preferably two women with some previous schooling and thereby not completely illiterate. These girls become co-tutors and assist their fellow students in their learning. In addition to the co-tutors there are senior students. The senior students have completed the 6 month course and stayed on to continue their education at the Institute while simultaneously completing their government schooling. The senior students choose a field of interest and their role becomes to facilitate the rest of the students in that particular subject.

The health manual covers a broad spectrum of common illness, health and hygiene practices. For each illness or practice it explains the cause, preventative measures, home remedies,
treatment and when medical attention is necessary. The manual is divided into some 150 one hour sessions all organized in a similar manner with both content and procedure of every lesson explained in full detail. Each afternoon the senior students with health as their chosen field will prepare the following day’s lesson by reviewing the manual (and turning to the director for advice if necessary). During class, the senior girl will facilitate the full group of women in learning that day’s session. Each co-tutor has also read through the lesson for the day in advance and will in turn assist her own group in their learning which is done together through conversation in the groups and the students fully involved in each step of the learning process. Different techniques for memorization, such as songs, games, role-play, storytelling and discussions on each subject is taught and performed. Previous lessons are revised at the start of every new session and at the end of each, and oral tests on important information is carried out. Later on when the girls are literate, written tests are also conducted. The facilitator summarizes the class at the end to make sure all important information has been understood by the group. If there are any questions or uncertainties, the facilitators have access to both the director and/or the chief operating officer at all times.

*Empowerment through education*

By having this system of tutors and co-tutors it is manageable for the Institute to teach such a large quantity of women simultaneously and also be sure that the information is thoroughly understood by each individual. Another important aspect is how the role as a tutor or co-tutor strengthens and empowers the women. It was clearly visible, both during observations and interviews, that there was an obvious correlation between the degree of increased responsibility and sense of empowerment within the women. By assisting their peers in their learning they both become confident in their own level of knowledge and also in their ability to share information and make an impact on others.

*Abolishing superstition*

Looking at the low spending on health care by the Indian government, the low status of women, the scarcity of medical staff and access to health care facilities, it was easy to assume that these were the main reasons for women not receiving proper medical treatment in rural areas. During interviews it also became apparent that strongly rooted superstition played a major part in this question. Without exception all of the women interviewed had some access
to educated medical staff (ranging from daily to monthly access), they all reported that seeing a medical doctor or a local healer did not vary significantly in cost. Still all women reported that before joining the institute there was a strong preference to seeing a local healer. The trust for trained medical staff is very low in rural and tribal areas and the believes in evil spirits and curses as main causes for illness along with a firmly established trust in the local healer seem to be the predominant reasons. When asked who they would choose to see upon returning from the institute, all of the interviewed women had now changed their preference to choosing trained medical staff over the local healer and attributing this change to increased knowledge about the origin of decease and acquired trust in western medicine. When asked about factors they believed would be conducive to their fellow women’s health in their villages all women mentioned education and the abolishment of superstition in regards to health practices.

Discussion

In an environment such as these women’s, where needs are both numerous and inter-connected, it might prove difficult to discern the most basic or fundamental ones. During the time of data collection a pattern emerged that pointed to three key elements; the importance of access to knowledge, the ability to comprehend it and the tools to apply it to one’s own life. In almost every sector of the women’s lives, be it prevention of disease, empowerment, abolishment of superstition etcetera, the same pattern remained.

There is a concept; health literacy, which is relatively new to international health research (and introduced in Sweden as late as 2009 by Mårtensson and Hensing). In a concept analysis, Speros (2005) defines health literacy as reading- and numeracy skills along with the ability to understand and use information to make health related choices. As seen in this study, the women at the Institute were unable to comprehend and influence their own health before joining the Institute and gaining basic skills such as literacy and numeracy along with health training. Only then were they able to discern their needs and understand the means to address them.
Also apparent in this study is how vital the element of empowerment is in creating lasting changes for the women. Were they only to receive health information without the additional elements being taught at the Institute such as vocational training, development of myself and my community or literacy it is unlikely that they would have been able to understand the concept of health from an holistic view point nor acquired the necessary strength of character to maintain changes and influence others upon return to their home environment. WHO (1998) have expanded the concept of health literacy to also include knowledge and individual capacities to take ownership of one’s own life and make changes in lifestyle and living conditions in order to improve health. They go on to claim that health literacy is critical to empowerment as well as personal, social and cultural development.

Several studies suggest that health literacy has a greater impact on the health status of a population than factors such as ethnicity, age or socio-economic status (Mårtensson & Hensing, 2011; Lindau, Tomori, Lyons, Langseth, Bennett & Garcia, 2002; Schillinger, Grumbach, Piette, Wang, Osmond, Daher, Palacios, Sullivan & Bindman, 2002; Speros, 2005). This can be seen in the work of the Institute where the previously mentioned parameters remain the same for the participants before and after their stay. Their general health is improved as a direct result of their increased health literacy which is obtained through the interdisciplinary education where numeracy- and literacy skills are combined with health education, vocational skills as well as empowerment training, all contributing factors to increasing health literacy and consequently the health status of the participating women. The term health literacy can be used in any population to describe the ability of an individual to consume information, comprehend it and make appropriate health related choices (Mårtensson & Hensing, 2009; Nutbeam, 2006; Speros, 2005, Schwartzberg et al. 2005) which for the women at the Institute was not an existing reality upon their arrival. Having no means for obtaining information due to inadequate access and illiteracy, while also lacking tools to interpret data, they did not possess the necessary skills to make informed health choices. Since health literacy is not a static state but can alter for each individual depending on internal and external circumstance (Mårtensson & Hensing, 2011) a significant improvement in health status of the participating women was achievable in a relatively short time-span due to the Institute’s insight in working with the key elements critical to raising health literacy.
When viewing a population such as the one depicted in this study, it becomes evident that the current trend of compartmentalization in regards to addressing women’s health in developing countries is unlikely to support a sustainable, long-term development in the field. To concentrate national and foreign aid efforts on selective, isolated measures seem to hold less potential for a successful raise in the general health of a population than when a holistic approach is being used. Studying the work of the Institute and the current research on health literacy, it has become clear how the importance of health education is closely linked with teaching numeracy- and reading skills as well as empowering a population in order for them to make informed choices and creating lasting changes. For the nursing profession this poses a challenge no matter in what continent or context one is working. If we want to see lasting health improvements we need to take an active role in promoting health literacy. Speros (2011) calls out for nurses to get involved in research, education and promotion of health literacy and make it a daily part of the profession’s routine practice.

**Methodological consideration**

Bearing in mind that everyday life, concerns and pre-existing needs of tribal and rural women of India is vastly different from a Scandinavian setting and with little to no existing literature shedding light on the reality of these women’s lives from an emic perspective, a good knowledge-base as a foundation for research was hard to establish. The planned questioners and methodology proved to be irrelevant once on site. The pre-understanding that these women could be asked to give an account of their own health needs was disposed of once conversations reviled that they did not possess the necessary framework and knowledge to do so. In order to not make similar miss-judgements, previous questioners and study design were discarded and an ethnographic approach was chosen in its place. To get a deeper and broader understanding of the questions of interest, the ethnographic method was selected on the basis that the researcher enters the selected field with an attitude of learning and an inductive approach to the development of the research process, where participating observation and conversations reveal patterns that in turn has the potential to lead the researcher to form hypothesis and theory (Holloway & Wheeler, 2002).
In order to gain trust and acceptance from the participants, the initial six weeks of the study were spent in participating observation (cf. Kvale & Brinkmann, 2009). No interviews were conducted during this time, but a detailed revision of the health curriculum was undertaken in order to get an understanding of the level of knowledge in regards to health the women possessed upon their arrival. To get an insight into what is being taught throughout the duration of the course and the methods used for implementing it, conversations were held with the chief operating officer (ibid.).

Due to the language barrier towards a majority of the individuals being interviewed, the use of a translator was required. Under the prevailing circumstance it was considered appropriate to use the director of the institute for this purpose. Even though her presence might have a limiting impact on the replies from the participating women due to matters of loyalty, this was weighed against employing an external translator. To employ someone external posed several difficulties such as finding a competent and reliable translator in the area, the financial aspect of conducting a low-budget study, but the foremost reason for choosing to use the director was her pre-existing knowledge of the content of the study, her insight into the health program and her good relationship to the participating women which would make them feel at ease and possibly more comfortable to express their views than with a stranger present.

In order to increase the validity of the findings, triangulation was implemented. Triangulation is commonly used in qualitative research as a means for establishing and controlling the validity of the results through different systems for comparison of data. Triangulation can be conducted through various methods, and in this study the use of data triangulation and method triangulation were incorporated to strengthen validity and ensure a broad information base (cf. Guion, Diehl & McDonald, 2002). Data triangulation consists of the use of several sources of information (ibid.). In this study the sources of information were the women studying at the Institute as well as staff. Method triangulation was ensured by collecting data both through participatory observations and field notes combined with conversation and interviews.

When analysing ethnographic data, where a large portion is gathered through observation and using oneself as an instrument there is always the case of personal interpretation and a potential risk of speculation. Therefore it is important to remember that the aim of the study is
not to validify a theory or claim a result to be transferable to other environments. It is simply to strive to present an emic perspective, bearing in mind that all experiences are filtered through the eyes of the current observer (cf. Murchison, 2010).

**Concluding remarks**
Due to the complexity of the concept of health and how it spans over all arenas of an individual’s life, it would have been desirable and necessary to shed light on all of the areas that the Institute is working on, such as the realisation of cast and gender equality, vocational training, improvement of the local community etcetera in order to gain a fuller understanding of how to create positive conditions for supporting women’s health in congruence with their needs. Unfortunately this was not possible within the limitations of a Bachelor’s Thesis.

There are a number of successful grass root models internationally that have managed to raise health literacy and health status in women. In order to learn about the important elements in doing so, it would be beneficial to study and compare several of these models.

There is also an apparent, vast shortage of nursing research in the area of women’s health needs in the developing world that reaches beyond their reproductive role. In today’s world this should not have to be the case. Having knowledge of health and access to care ought to be a basic human right implemented for all, and the fact that it isn’t, is of global concern.

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