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Understanding Social Determinants of Health: Lessons from a South African Rural Community

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Abstract

This study has been influenced by the growing health trends around the world. There has been growing interest in social determinants of Health (SDH) and more attention has been given to African Indigenous health practices. SDH in other words clarify why different social groups experience different health outcomes. In this regard specific factors remain to be identified. This study looks to identify different SDH vis-à-vis indigenous healthcare practices in a South African rural community. The researcher conducted in-depth interviews with mature respondents aged between (18-65 years). Criterion purposive sampling was used to select respondents from Dikgale community in the Limpopo province, South Africa. Thematic content analysis was employed to analyse the data from the interviews. This research identified seven (7) social determinants of health factors which pose a great danger to the health of the people in Dikgale community. It has also been discovered that the community prefers the use of traditional health care systems compared to the western health models. Most of the health problems in Dikgale community as cited by the participants emanate from the social determinants such as housing, income, unemployment, cultural taboos or restrictions, different health care systems, gender inequality and education. This case study emphasized the significance of addressing SDH in the administration of healthcare programs in low socioeconomic contexts. Not only did the SDH impair access to good jobs, adequate housing, and food, but environmental constraints also affected people's lives.

Keywords: *Social Determinants of Health (SDH); Health Promotion; African Indigenous Knowledge Systems (AIKS); Health Care System*

Introduction

Since acquiring independence and the advent of democracy in 1995, South Africa has been facing a huge burden of disease, conditions related to poverty and underdevelopment, HIV and AIDS, chronic diseases, and injuries (Bradshaw, 2008). Raphael (2009) states that the term "social determinants of health" has grown out of researchers' attempts to identify the specific health exposures by which

members of different socio-economic groups come to experience differing health outcomes. The SDH determines the extent to which a person possesses the physical, social, and personal aspirations that satisfy their needs and cope with the environment. Seskar-Hencic, Cambell, Rainville, and Brooks (2013) concur when they point out that social determinants of health are the conditions in which people grow, live, play, work, and age, including the health care system. The SDH also includes other factors which determine health outcomes, such as income, housing, education, and the country's social services. In other words, social determinants are about the quantity and quality of resources a society makes available to its community members.

Building on the Millennium Development Goals, the United Nations suggested a sustainable development agenda to address social inequities (UN 2015). The agenda includes 17 SDGs (sustainable development objectives) with economic, social, and environmental components (UN 2015). The SDGs address a wide range of challenges, from poverty eradication (goal 1) to providing access to water and sanitation (goal 6) to making human settlements inclusive and safe (goal 11). (UN 2015). Reducing health inequalities would necessitate an awareness of the SDH specific to each country's situation, particularly in African settings (Ataguba, Day, & McIntyre 2015).

Research has shown progress made so far in South Africa to address SDH since 1994. In-depth Training and Research Centres of Excellence (INTREC) in 2012 published research results which show the analysis data based on the reports from Statistics South Africa (StartsSA), the South Africa Demographic and Health Surveys (SADHS), development reviews, such as the mid-term review of development indicators, and the macro-social review conducted by the government. The study revealed that national economic and social policies have resulted in economic growth and there has been some improvement in living conditions through access to basic services such as water and sanitation. There is still a shortage of electricity in some parts of the country. Lastly, the study revealed that despite the increase in social grants, extreme wealth inequalities and high levels of unemployment play an important role in the poor health outcomes experienced by the population. This shows that despite the efforts that have been made so far, SDH factors remain an issue that needs attention.

Table 1. Trends in social determinants of health (1996 - 2008), South Africa

Trends in social determinants of health (1996- 2008)

- **An improvement in living conditions, namely housing, water, sanitation and electricity:**
- **Proportion of households with formal housing increased from 64.4% to 70.5%, whilst those with informal housing decreased from 16% to 14.5%**
- **Proportion of households with piped water increased from 81.2% to 88.6%**
- **Proportion of households with a flush toilet (includes chemical toilet) increased from 50.5% to 57.9% whilst those with no toilet reduced from 12.4% to 8.2%**
- **Access to electricity increased rapidly with proportion of households with access to electricity increasing from 57.6% to 80%**
- **Unemployment increased between 1994 and 2003 (from 20% to approximately 30%), then decreased to 23% in 2008**
- **Unemployment remains high amongst the African group and was estimated to be 23% amongst men and 31% amongst women in 2008**
- **Proportion of the population without any schooling decreased from 19.1% to 10.3%. The greatest improvement is amongst those with some secondary education where proportion has increased from 33.6% to 40.1%.**
- **Higher level education has not improved much with a 2% increase in the proportion of population with higher education between 1996 and 2008**

Source: (INTREC, 2012:25)

The general impression from table 1 is that there has been an improvement in the living conditions in South Africa since 1996, housing, water sanitation and electricity supply. One would assume that, based on these statistics and trends, they have continued up to this day. All other services, from electricity to secondary education, the proportion of households' water seems to have increased and households that use flash toilets in the period between 1996 and 2008. This is not the case with employment, which continues to rise and slump. The most intriguing aspect would be to note if these trends are the same country-wide in the rural community.

This current study looks at the social determinants of health facing the rural communities in South Africa. This is because most beneficiaries of government policies are in urban areas. In Africa, wide inequalities exist within countries, especially in South Africa (Scott et al. 2017). Historically, policies and economic development focused on the needs of the urban population, which led to underinvestment in rural communities, thus contributing to their marginalisation (Marmot et al. 2008). Before the whole nation has electricity, research can pinpoint that it is rural areas that do not have electricity and services such as education, water piping, clean water, and flash toiletries. Rural communities may also be experiencing higher unemployment rates than urban areas. It is more likely that when trying to deduce from the statistics above, one can note that between 1994 and 2003, unemployment increased from twenty percent (20%) to thirty percent (30%) and in 2008 it was reduced by thirty percent (30%). These trends affect the rural community much more, where there are fewer employment opportunities. South Africa's rural areas are characterized by sparsely populated countryside with tiny villages or towns where the population relies mostly on agriculture, government assistance, and migrant labor for subsistence (Maredza, Bertram & Tollman 2015; Neves & Toit 2013). Typically, these regions are former homelands characterized by traditional communal land tenure arrangements (Fay 2015; National Treasury 2011). This inspired the current study to focus on rural areas, so that the social determinants of health are laid bare in the open. This will ensure that more SDH-related policies are developed to assist in the development of rural communities' lives.

Methods

Study Population and Procedures

Data were collected from research participants from Dikgale community between August and September 2021 in Capricorn District Municipality of the Limpopo Province. The district is 90% rural and it covers an area of 13235 km² with a population of about 155881 and an average density of 87 people per km² (Rankoana, 2000). Dikgale community is inhabited by Bakone-ba-Dikgale. The community lies in a semi-arid to arid climatic type with an annual rainfall of approximately 505mm. Daily average summer temperatures range between 16, 9ºC and 27, 8ºC. Winter temperatures range between 4.3ºC and 19.8ºC. Summer rainfall occurs between October and April, followed by a dry winter season (Weather Bureau, 1986). Dwelling units consist of a mixture of shacks, traditional mud huts and conventional brick houses (Rankoana, 2000).

Data Collection

In-depth interviewing is the only method which was chosen to collect data. Rankoana (2012) and Nyahunda et al. (2017) state that in-depth interviewing involve face to face interaction between an interviewer and the study participants, which seeks to build the kind of intimacy that, is common for mutual disclosure. The main advantage of in-depth interviews is that they create a dialogue between the researcher and the participant. The in-depth interviews were useful in providing useful information regarding SDH facing the community members.

Data Analysis

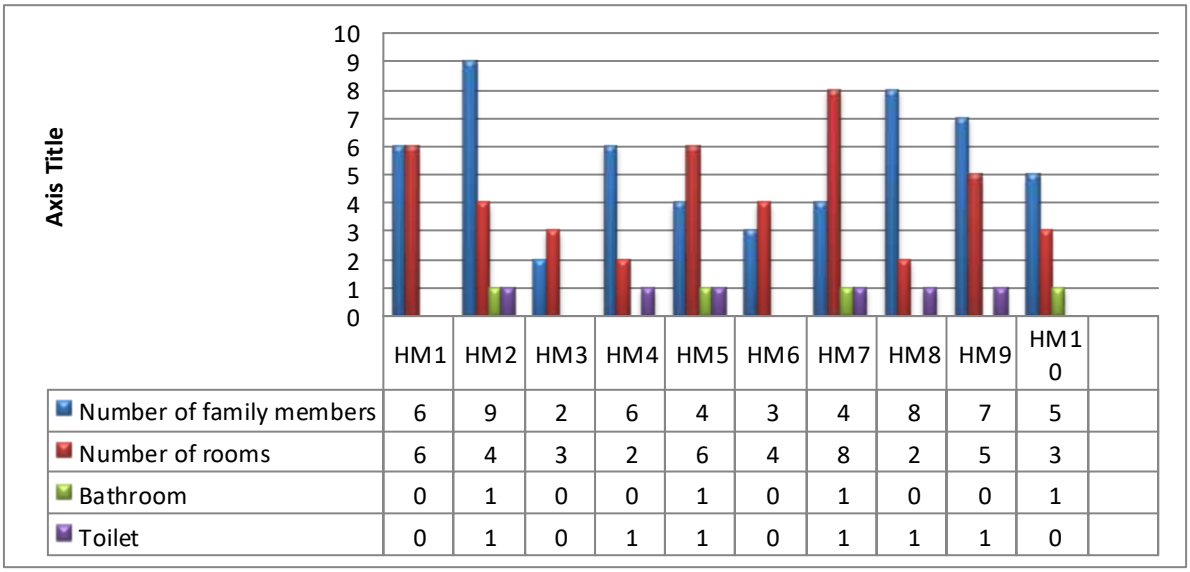
Data was analysed using thematic content analysis. The data was reduced into themes which were emerging after a thorough reading and transcribing of data (Burns & Clarke, 2006). Pattens emerging were coded and classified into different categories. The process included looking and taking note of the relationship between themes and sub-themes coming from the data collected.

Results

The Grassroots and Village Responses to Social Determinants of Health

The objective of the study was to describe the social determinants of health faced by people in the rural community. In this case, it becomes imperative to understand health problems which are faced by people in the community. This can be understood by knowing the social determinants of health in this community. Addressing the social determinants of health would ensure that community members live a healthy life. The respondents highlighted several factors which have a bearing on their lives.

Housing



	HM1	HM2	HM3	HM4	HM5	HM6	HM7	HM8	HM9	HM10
Number of family members	6	9	2	6	4	3	4	8	7	5
Number of rooms	6	4	3	2	6	4	8	2	5	3
Bathroom	0	1	0	0	1	0	1	0	0	1
Toilet	0	1	0	1	1	0	1	1	1	0

Figure 2: Number of family members and type of house. Source: Author

The housing domain offered a snapshot of different types of homes seen in low socio-economic settings in South Africa. The participants were asked to describe their living arrangements and the type of household in which they live. The aim of this question was to make an analysis of housing as a social determinant of health among people living in the Dikgale community. Looking at figure 1, the researcher noted that it was the participants HM5 and HM7 who had quality housing, which can create a safe environment for living. As per participant HM5, one can note that they have six rooms, a toilet, and a bathroom for a family of four, whereas participant HM7 has eight rooms, a toilet, and a bathroom for a family of four. Furthermore, when compared to other participants, these two participants come from better-off households.

This scenario of the living order of HM5 and HM7 mentioned above comes in deep contrast with participants HM1, HM3, and HM6. These participants come from three different households, but they

share the same characteristics in common. The number of rooms they have is more than the number of people available to occupy them, and that is good for their health. However, they all lack a toilet and a bathroom. Participant HM1 had this to say: *"A six-room house is not enough because I need my own place. Here is my parents' house." A bathroom is needed, and a toilet is needed. "* These sentiments coming from participants showed the emotion that these participants have about the place where they are living, and they feel there is a need for upgrading. The participants desired homes that are warm and stable, and homes that offer safety and space to develop.

Lack of Income

The researcher went on to question the participants about the factors that may affect that individual's health. Fifty percent of the participants agree that they have a lot of stress from financial matters, and they believe it affects their health and life a lot. Women participants also stated that they are frequently involved in financial arguments with their husband. This is more often accompanied by a lack of attention to their needs. When their husband does not meet their financial needs, all the married women polled reported feeling stressed. Here is what participant HM5 had to say about herself:

> *"I feel that my health is at risk when I think too much about money and lack of attention at home. For instance, I don't enjoy being ignored... When I am talking to my partner about our budget, my husband is supposed to listen"* (Participant HM5, woman, married, 28).

In this case, the participants concur that a lack of income would affect individuals' personal choices when it comes to buying food for nutrition. It is quite evident from the assertion above that lack of income increases the chances of one getting stressed. The participant HM10 makes an overall observation that the youth and other community members end up resorting to unsafe jobs, which in turn may affect their health. The participant states that: *"Unemployment in this community is too high and many of the youth find it difficult to find jobs and they end up resorting to unsafe jobs, for instance, making bricks and engaging in drugs."* This is the view shared by all the respondents that their health is more likely to be affected by the lack of employment. In the long run, a lack of job opportunities leads to a lack of income, which has serious consequences for the type of food one eats and the type of housing one lives in, among other things. Saving seemed to be less of a priority, with only a few participants investing in the future. However, a household surviving on a government grant did not necessarily provide them with the capacity to save for the future. Eleven participants had a financial safety net, which came in the form of support provided by family members or child support grants.

Water Problem

The fourth problem which has been identified is water problem. Approximately thirty percent (30%) of the participants noted that here is water problem in some parts of this community in which people must wait for water to come with trucks in the streets. Lack of delivery of water at designated points also mean people would have a problem in maintaining their health. Moreover, some would resort to taking water from the dams. Participant HM1 describes the situation:

> *"In some areas there are water problems, and they use the machines to pump water, in an event that there is no water most of the people are able to take water from the dam whilst others have to wait for drums to be placed for them to collect water*" (Participant HM1, woman, married, 52).

These two respondents agree with other respondents about the gravity of the water problem which may compromise the health of other people. The third explanation given to the problem of water was attributed to the incompetence of the local municipalities. The participants felt the officials should ensure that the area's water supply is kept up to standard and most of the respondents felt betrayed by the officials whom they expect to serve them in honest and ensuring that there is service delivery. Here is

what respondent HM1 had to say about the problem of water supply: *"This problem is caused by our corrupt leaders; most of our leaders are not working for the community".* In other words, one can note that the dissatisfaction of the community members highlights their concern about their health. Lack of water supply will eventually result in the quadruple of diseases in the community. Furthermore, lack of water points out to the need for the serious attention this problem as a social determinant of health. In the absence of safe running water, all the rural and four urban participants made use of either pit latrine, communal toilets or they would choose to relieve themselves in nearby fields or forest. The lack of basic sanitation amenities inside the home made it necessary for the women to mobilise outside their home and negotiate rough terrain, which they found problematic.

Cultural Taboos or Restrictions

This category has been established to go deeper into investigating the social determinants of health in this rural community, and in this case, the cultural aspect is brought forward. The respondents were asked this question: "Are there any cultural taboos or restrictions that may influence your health?" When asked this question, most respondents did not have a particular answer to this question. The reason for this was that most of them believed that culture had no effect on them; however, women respondents blamed culture for their health problems, claiming that they are forced to consult their husband before going to a hospital or clinic out of respect for their husband. Participants HM10, HM8, HM7, and HM5 all agreed with this, as noted by HM7 below:

> *"You see, my brother, I am not the one in control. Before I go to the doctor, I must consult my husband. Sometimes he prefers to consult a traditional healer, and yet I want to go to the doctor, but what he says go, he is the head of the family, I want my family." (Participant HM7, woman, married, 32).*

All the female respondents agreed that they have limited choice when deciding on the health care to attend and they end up going to the health care they had not planned to attend. The next cultural restriction which falls under the theme of patriarchy is the choice of spouse issue. All the female respondents agreed that their lives are in danger in the case where it happens that their spouse dies; they could be inherited by a brother of their husbands or father. In this culture, they are not allowed to choose another spouse, but they get inherited like any other property, and with diseases like HIV and AIDS, their lives are greatly in danger. Here, respondent HM10 explains this cultural tradition. *"Well, when my husband dies, I can be given to another... his brother or even his father in the absence of the next of kin... this I think it places many women's health in danger...".* There are two themes that have been identified by the researcher in this category: gender inequality and patriarchy. These are two important themes which require attention. For instance, they have serious implications for women's lives. They would probably determine the health outcomes of a woman.

Health Care Preference

In this category, participants were asked, "When you are ill, which health care facility/ties do you prefer, i.e., traditional healer, clinic, hospital, prophet, and if other, please specify." When they become ill, 40% of respondents choose traditional healers as their first point of contact. Twenty-five percent (25%) of participants chose to utilize the hospital as a health care option. Twenty percent (20%) of respondents indicated that they would prefer to obtain medical care at a clinic, which is the least preferred health care facility. A new subcategory does, however, develop in a sense. Two respondents, or twenty percent (20%), have said that they favour both the clinic and the traditional method.

The participants were then asked to justify their responses, and most respondents claimed they chose traditional healers because they knew their requirements better than a national health care system, and it was also less expensive. The response from HM9 was as follows. If I see a traditional healer, I don't have to spend a lot of money, and yet they are successful. Secondly, other respondents provide an intriguing perspective: they favour both traditional and clinic-based care because clinics and traditional healers are located closer to their community than hospitals. In addition, ten percent (10%) of respondents indicated that they have other diseases that can only be treated by a traditional healer, where you feel more secure than in a hospital, and because of their traditional values, some other respondents, especially the elderly, prefer traditional healers over hospitals. Consultation with a traditional healer is the most probable course of action for maintaining one's reputation and privacy, according to the participants. "There are some disorders for which I would visit a clinic or hospital, but for sexually transmitted diseases, it is preferable to visit a traditional healer since they preserve secrets, and no one will see you." Lastly, based on the presentation of results in this area, about six themes have emerged as health problems or have had a significant impact on the health of community members. The researcher identified the following socioeconomic determinants of health in this community: housing, lack of income, unemployment, water issues, cultural taboos or prohibitions, and health care choice.

Key Findings and Discussions

Social Determinants of Health

In accordance with the assumptions made in the introduction, according to Raphael (2010), the term "social determinants of health" arose from researchers' efforts to identify the exposures that cause people of different socioeconomic groups to have varying health outcomes. These resources include the conditions of childhood; income; availability and quality of education; food and shelter; employment; working conditions; health and social services; and so on. Raphael, Marcia, and Roux (2010:206) acknowledge that an awareness of social health determinants assists in dealing with them and highlights the limits faced by health promoters, leading to a reorientation of public policy to the social determinants of health because of the research. This study has identified nine socioeconomic determinants of health that constitute a significant threat to the health of the Dikgale community's residents. These social variables and the effects they have on individuals and the community at issue are discussed. Figure 1 highlights the social determinants of health discussed in this paper.

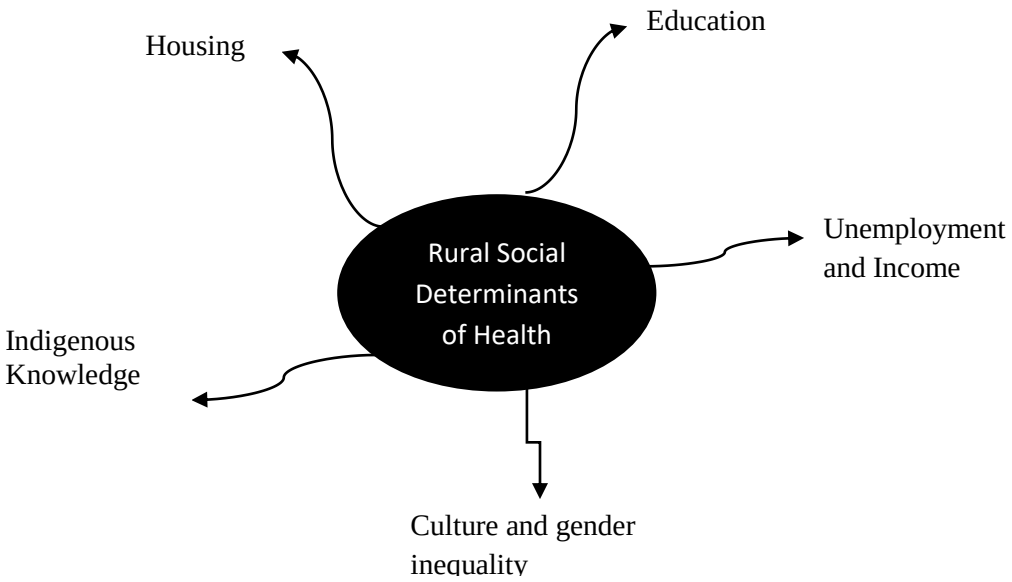


Figure 1. Rural Social Determinants of Health
Source: Author

Housing

The research found out that most of the people in the Dikgale community do not have enough housing to accommodate the number of people per household. The results found out that there are usually more people living in a few rooms and they lack toilets and bathrooms, which has a serious implication on the lives of the people. The problems which can emanate from this include poor sanitary conditions, which in turn can lead to health problems, for instance, the outbreak of cholera. Butler-Jones (2008) notes that in his study that the consequences related to the inability to afford a suitable housing situation include food deprivation or substandard housing conditions. For instance, some people will end up living in squatter camps in which there is water shortage, no electricity, and poor sanitary conditions, which can lead to various health hazards, for instance, the spread of diseases like cholera, tuberculosis, flue and many other diseases. In this case, these are some of the health problems already affecting some of the people in the Dikgale community.

Unemployment and Income

The participants complained about their income, and none of the respondents were working professionally, indicating that their wage is inadequate. Most participants indicated that their health is influenced by their money since they cannot purchase as much healthy food as they would like. They had fewer options when it came to food due to a lack of funds, which negatively impacted their health. This is supported by the literature, which explains this problem in greater detail, for example, according to the research conducted by Raphael (2008). Raphael (2008) concurs with this research's conclusion when he argues that without adequate income, access to food, quality housing, and other basic prerequisites of health becomes increasingly difficult to obtain. These are some of the experiences that the residents of Dikgale have because of their income being mostly determined by other social factors, such as unemployment. According to the report, there is a high unemployment rate in the Dikgale neighbourhood, and most young people are turning to more dangerous vocations. This has a significant impact on the health of the individuals in question as well as the health of the community, as seen by the fact that more people end up misusing alcohol, experiencing higher levels of stress, and having poor nutrition, as stated in the presentation of results. In their research, Seskar-Hencic et al. (2011) found that unemployed or underemployed individuals have the highest death rates compared to employed individuals. People who have control over their employment circumstances and fewer stress-related demands at work are happier and healthier than those who do not. Given that many individuals in the Dikgale community are unemployed and there are few professionals, this indicates poor health.

Education

Ungerleider, Burns and Cartwright (2009) they found out that education is an important social determinant of health, people with higher educational tend to be healthier than those with lower educational attainment. This in relation Dikgale community the study most of the population is uneducated, and this has huge implication on their health. Consequence it leads to poor choices like early sexual activities as revealed by the research. Earlier discussion on income shows that income increases the choices one has in terms of buying health food. In this case education ensures that, one gets a good job and a better income.

Culture and Gender Inequality

The researcher has combined the two factors together because of the way they emerged in the results. In this research it has been discovered that patriarchy still has its hold on people, and it is the

African culture which perpetrates patriarchy and as result there is gender inequality between males and the females. Women have limited choices when it comes to health matters while men can choose which health care a woman can consult. This can affect the treatment which women can get and another factor which perpetrates gender inequality is the inheritance issue. This happens when the husband dies, and a woman is given to another, and this exposes women to unknown diseases and limits women's choices when it comes to their health. Bryant et al. (2010) agrees with the research findings this research they also have less access to, and utilisation of health services are influenced by cultural and ideological factors such as embargoes on consulting the male practitioners due to the suspicious husbands, lack of freedom to act without the permission from their husbands.

The Indigenous Knowledge and the Social Determinants of Health

Indigenous knowledge (IK) is described by Warren (1992) as concepts that are ingrained in the minds of individuals. IK is the systematic body of knowledge acquired by local people through the accumulation of experiences, informal experiments, and intimate understanding of the environment especially in relationship to land in a given culture (Ngara, 2013; Tirivangasi & Tayengwa, 2017). It is true that indigenous knowledge and SDH are related. SDH, according to Raphael (2010), is all about the kind and number of resources that society makes available to its people, including the circumstances surrounding children, food, housing, jobs, working conditions, health, and social services. The health results of a specific community can be directly impacted by the knowledge that the people possess. The community members have cultural beliefs that are a part of IKS, and they use IKS to develop coping mechanisms and approaches for SDH. Eighty percent of South Africans, according to Mbatha, Street, Ngcobo, and Gqaleni, use traditional remedies to take care of their basic medical needs. The expert also pointed out that Africans have long used traditional remedies. IK is passed down from one generation to the next, and it is these convictions, ideas, practices, and wisdom that equip a community to handle the SDH. In conclusion, it should be noted that it is obvious that healthcare influences people's health outcomes. According to this study, more than 50% of residents of this rural community prefer the traditional healthcare system, while a sizeable proportion also use the Western healthcare system.

Child Development

The availability of social determinants like unemployment, poor housing, income, education and other mentioned above has high implication on child development. This research has shown that poor nutrition is cited as emanating from lack of grocery shops which sell health food. The other factor which is affecting child development is the fact young people are sexual activities this has huge impact on the development of child because the respondent in this research noted that there is higher prevalence of sexually transmitted diseases. Seskar-Hencic et al (2011) concur with the research finding when they note that children who live in low-income household are susceptible to chronic disease, substance abuse and mental difficulties. This is likely to affect them the rest of their life.

Conclusion

In summation one can conclude that it is imperative to understand the societal social determinants of health before embarking in health promotion activities. Most of the health problems in Dikgale community as cited by the participants they emanate from the social determinants such as housing, income, unemployment, cultural taboos or restrictions, gender inequality and education. These social determinants of health have a serious implication of the health life of the individuals and the community at large. The availability of these social determinants of health mentioned above has resulted in community health problems. Other societal health problems which have emerged include drug and alcohol abuse which can be attributed to unemployment, poor nutrition which have been attributed to lack

of sufficient income, poor infrastructural development, and lack of health food available or choices. According to the WHO commission on SDH, access to decent housing, potable water, and sanitary facilities is a fundamental human right and, consequently, essential for maintaining good health (Marmot et al. 2008). The absence of access to sanitary facilities and clean, running water violated the fundamental human rights of most women in this survey. Inadequate water and sanitation, in conjunction with substandard housing, not only exacerbate health inequities, but also suggest poor functional outcomes for stroke patients (De Villiers et al. 2011). The findings of this study are compatible with United Nations Sustainable Development Goal 6, which calls for equitable access to clean water and sanitation (UN 2015). The United Nations also urges that local communities encourage and expand their participation in efforts to improve water and sanitation management. Water is essential for life and is utilized in cooking, cleaning, and self-care. In addition to being concerned with the consequences of health and disease, the health and rehabilitation sectors must take the initiative to ensure that health equity is addressed in sector policies, procedures, and programs (Marmot et al. 2008; Scott et al. 2017).

Recommendations

Firstly, this recommends promoting health in all policies (HiAP) approach. This can go a long way in promoting people's lives in several ways. This research finds out that people don't have shops to buy healthy food, need to be educated, need employment, need a clean environment, housing, and other social determinants of health. This cannot be the role of the ministry of health alone but requires collaboration between ministries to ensure a healthy society. Secondly, infrastructural development is recommended. The research found out that most respondents complained that in the Dikgale community there are grocery shops which sell healthy food. People must travel to town to go and buy food. The government should create a local growth point in the Dikgale community from which the community can access healthy food and supplies. Further, the government should improve housing conditions. For instance, it should help families to build toilets and bathrooms and help them to extend their houses so that they are able to accommodate the number of people per household. Thirdly, this research recommends the promotion of observance of social determinants of health. It has been found that understanding the social determinants of health will help in understanding health problems faced by people. This will in turn help in the creation of health promotion initiatives which are suitable for the community in question. Lastly, the research advocates for promoting the use of both traditional and medical health care. The research established that a strategic partnership between traditional healers and medical health care would go a long way in promoting and maintaining the health of the individuals and the community. Research has revealed that most people have a high preference for traditional healers when it comes to highly stigmatized diseases like sexually transmitted diseases (STIs). Apart from this explanation, one can note that quite several people still visit clinics and hospitals. This resulted in the belief that the use of both healthcare systems is of paramount importance for the maintenance and promotion of community health.

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