Unveiling the Impact of Culture on Quality of Life of Women: An Anthropological Insight from Munda Tribe of Odisha

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ABSTRACT

Quality of life (QoL) is a multidimensional concept that includes both positive and negative aspects of life. The quality of life of an individual is associated with standard indicators like environment, physical and mental health, wealth, education, employment, religious beliefs, and cultural patterns. Although quality of life is a complex concept that is interpreted and defined in several ways within and between various disciplines. Knowledge about quality of life is important for understanding the consequences of illness and treatment and for medical decision-making across age groups and cultures. This paper aims to identify the link between culture and quality of life from an anthropological perspective and to investigate how culture influences the quality of life of women. A cross-sectional study approach has been used to study the Munda tribal community in the age group of 18 and above in the village of Keonjhar district of Odisha to assess the quality of life and the association between culture and its impact on the quality of life using multidimensional interviews, schedules, and the WHOQOL-BREF scale of the World Health Organization (WHO) for an intensive study.
Keywords: Quality of life (QoL), Multidimensional, Interview, Schedule, Munda community, Women, WHOQOL-BREF, Keonjhar, Culture, World Health Organization (WHO)

INTRODUCTION

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[1] Article 25 in Universal Declaration of Human Rights speaks of the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[2]

Depending on the several health indicators, tribal women community lags behind the national average being the most vulnerable and they are not easily integrated into the mainstream of socioeconomic activities to cope with their health problems. Nowadays, tribal population suffer a vast burden of diseases namely, communicable diseases, non-communicable diseases, malnutrition, mental health, and addictions.[3] An exploratory study in Rayagada district of Odisha was carried out by Contractor *et al.* (2018) to understand tribal women's maternity care and their interactions with the formal health care system. They included in-depth interviews with women, traditional healers, and formal health care providers to seek their health

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[1] World Health Organization. (1946). *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference*: New York.

[2] United Nation. *Universal Declaration of Human Rights.* Available from: https://www.un.org/en/universal-declaration-human-rights/ (Accessed on 17 July 2023).

[3] Kumar, M.M., Pathak, V.K., & Ruikar, M. (2020). Tribal population in India: A public health challenge and road to future. *Journal of Family Medicine and Primary Care, Vol 9,* Issue 2, Pp. 508-512. https://doi.org.10.4103/jfmpc.jfmpc_992_19

seeking behaviour and their adopted practices. Their exploration resulted that, tribal women perform natural practices for their treatment and do not like to seek for any external interventions.[4]

Quality of life (QoL) is a concept which aims to capture the well-being, whether of a population or individual, regarding both positive and negative elements within the entirety of their existence at a specific point in time. For example, common facets of QoL include personal health (physical, mental, and spiritual), relationships, education status, work environment, social status, wealth, a sense of security and safety, freedom, autonomy in decision-making, social-belonging, and their physical surroundings. [5] Quality of life is a broad multidimensional concept that usually includes subjective evaluations of both positive and negative aspects of life.[6] It is the outcome of concern and its measurement and assessment has been the central focus of some drug trials and some clinical trials at the National Institute of Health.[7] Mudi *et al.* (2023) have carried out one study on the menstrual health and hygiene among the Juang women in Odisha to provide an insight into the sensitive issue of their mode of practices. They performed cross-sectional study with mixed approach among 360

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[4] Contractor, S.Q., Das, A., Dasgupta, J., & Belle, S.V. (2018). Beyond the template: the needs of tribal women and their experiences with maternity services in Odisha, India. *International Journal for Equity in Health, Vol 17,* Issue 134. https://doi.org/10.1186/s12939-018-0850-9

[5] Teoli, D., Bhardwaj, A. (2022). Quality Of Life. In: StatPearls. *National Center for Biotechnology Information.* https://www.ncbi.nlm.nih.gov/books/NBK536962/

[6] The WHOQOL Group. (1998b). The World Health Organization quality of life assessment (WHOQOL): Development and general psychometric properties. *Social science & medicine,* 46(12): 1569-1585. https://doi.org/10.1016/S0277-9536(98)00009-4

[7] Bergner, M. (1989). Quality of Life, Health Status, and Clinical Research. *Medical Care*, *27*(3): 148–156. http://www.jstor.org/stable/3765660

newly married women, 15 focus group discussions and 15 in-depth interviews among the Juang women to explore their practices, cultural beliefs, menstrual problems, and treatment seeking behaviour associated with menstruation and its management. They found 85% women used old clothes as absorbents during menstruation, 85% women were restricted from participating in any religious activities, 94% women avoided social gatherings, 71% women experienced menstrual problems, out of which only one-third of them sought treatment for their problems.[8]

A famous definition of culture given by E.B.Tylor in his book *Primitive Culture* (1871) which states that, "Culture is that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habit acquired by man as a member of society".[9] Shaw *et al.* (2009) had examined how the role of culture influences on health literacy where cultural and language differences along with socioeconomic status are the major contributors.[10] Blindfolded by culture, lack of awareness related to the health-seeking practices, and majorly adopting their indigenous practices to treat their every health issue put them into trouble at times, which subsequently results into their vulnerability and low or poor quality of life among the women.

Therefore, the objective of this study was to unveil the impact of culture on quality of life of tribal women living in the rural area of Keonjhar district of Odisha, India.

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[8] Mudi, P.K., Pradhan, M.R., & Meher, T. (2023). Menstrual health and hygiene among Juang women: a particularly vulnerable tribal group in Odisha, India. *Reproductive Health, Vol 20,* Issue 55. https://doi.org/10.1186/s12978-023-01603-1

[9] Tylor, E.B. (1871). *Primitive Culture.* London: John Murray.

[10] Shaw, S.J., Huebner, C., Armin, J., Orzech, K., & Vivian, J. (2009). The role of culture in health literacy and chronic disease screening and management. *Journal of immigrant and minority health, Vol 11,* Pp. 460-467.

1. RESEARCH OBJECTIVES

i. To understand the relation between health condition and the quality of life of women.

ii. To find the relation between consumption of intoxicant and the quality of life among the women.

iii. To know the link between marital status and quality of life of women.

iv. To find the relationship between belief practices and respondents' quality of life.

v. To find the relation between mode of treatment and respondents' quality of life.

TESTING OF HYPOTHESIS

H1$_0$- There is no relationship between health condition and quality of life.

H1$_A$- There is a relationship between health condition and quality of life.

H2$_0$- There is no relationship between consumption of intoxicant and quality of life. **H2$_A$-** There is a relationship between consumption of intoxicant and quality of life. **H3$_0$-** There is no relationship between marital status and quality of life.

H3$_A$- There is a relationship between marital status and quality of life.

H4$_0$- There is no relationship between belief practices and quality of life.

H4$_A$- There is a relationship between belief practices and quality of life.

H5$_0$- There is no relationship between mode of treatment and quality of life.

H5$_A$- There is a relationship between mode of treatment and quality of life.

2.   MATERIALS AND METHODS

2.1 Area and population

The village *Kabitra* of Keonjhar district was the study area, and all tribal women (*Munda* tribe) living in the same region were considered as the population of this study. This cross-sectional study was conducted from February 10, 2023 to February 25, 2023. A total of 86 samples were collected from the respondents. The research was both qualitative and quantitative in nature. Total area of the Keonjhar district is 8,303 km^2, and 2264 people (male- 1172 and female- 1092) are living in the study area of this district. Keonjhar district is located in the northern part of Odisha. This district is bounded by Mayurbhanj and Bhadrak district to the east, Jajpur district to the south, Dhenkanal and Sundargarh district to the west and West Singhbhum district of Jharkhand state to the north. Keonjhar district has got 3 Tehsils, 13 Blocks, 297 Gram Panchayats, 2132 Villages, 4 Municipalities and 1 NAC functioning in the district. Total SC population of the district is 2,09,357 (2011 Census) and ST population is 8,18,878 (2011 Census). And about 50.3% males and 49.7% females respectively in the district.[11]

2.2 Inclusion and exclusion criteria

Researcher considered only tribal women present in the study area, who aged 18 and above, some samples were having non-communicable diseases and some were having no disease at all. People below aged 18 and individuals showing some sort of mental issues were strictly excluded from this study.

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[11] Government of Odisha *https://kendujhar.nic.in*

2.3 Sample size determination

The required sample size for this study was determined by using the formula,

n= N/1+ N*e², where n = sample size, N = population size, e = level of precision or margin of error = 0.05 at 95% C.I.[12] The formula provided that, 104 samples were the required sample size for the study. Since the total population of ST women was 140 in the study universe, who were aged 18 and above.

2.4 Sampling and data collection procedures

A simple random sampling or probability sampling was used in this study for selecting 86 individuals (38, 44.19% normal health condition and 48, 55.81% affected with non-communicable diseases). Out of 13 blocks in the Keonjhar district, Sadar block was purposively chosen; and out of 297 gram panchayats in the Sadar block, Bodapalashia gram panchayat was selected purposively selected because during literature review, there was a dearth of knowledge of any previously done study in this region's *Munda* tribal community, especially on women. Based on the number of tribal population (women) in the village *Kabitra*, 140 individuals aged 18 and above were selected by simple random sampling. All information regarding tribal population's health was collected from the Anganwadi centre and ASHA worker. Before collecting data, the objectives of this study were discussed with the ASHA worker and selected respondents as well. Later, most of the tribal women did not agree to provide their information, some were ill to the extreme, some were unable to convey properly; all those individuals were excluded from this study. Finally, 86 individuals were considered for this study. Data collection was done by various

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[12] Yemane, T. (1973). *Statistics: An Introductory Analysis.* London: John Weather Hill, Inc.

methods and sources such as; qualitative data was collected from selected samples using an open-ended interview, observation and focus group approach, while quantitative data was collected using close-ended interviews, schedules. Both, primary and secondary data were collected for this study.

2.5 Outcome variable

Quality of life of women was the dependent variable in this study, and it was measured by the scoring of WHOQOL-BREF. According to WHO (1996), "Domain scores are scaled in a positive direction, i.e. higher the score, better will be the quality of life".[13]

WHOQOL-BREF (1996)

It is a 26-item instrument consisting of four domains: Physical domain (7 items), Psychological domain (6 items), Social domain (3 items), and Environmental domain (8 items). It is the 5 point scale in which response categories.

2.6 Independent variables

The following socio-economic and demographic variables were considered as independent variables: age, sex, education level, marital status, occupation, household annual income, sanitation facility, electricity, communication, transportation, safe drinking water access and consumption of intoxicants such as, *alcohol, tobacco, smoking* etc. and health condition during the survey. The classification of the variables is described in the *Table 1*.

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[13] World Health Organization. (1996). WHOQOL-BREF: Introduction, administration, scoring and generic version of the assessment: field trial version, December 1996 (No. WHOQOL-BREF).

Table 1: Socio-economic and demographic characteristics of tribal women (n=86)

Variables	Groups	Value (n)	%
Age groups	18-30	29	33.72
	31-43	19	22.09
	44-56	26	30.23
	57-69	8	9.3
	70-82	4	4.65
Educational level	Non-literate	50	58.14
	1-5	14	16.28
	6-10	19	22.09
	11-12	1	1.16
	Graduation	2	2.33
Marital status	Married	75	87.2
	Unmarried	0	0
	Widow/Separated	11	12.8
Occupation	Business	1	1.16
	Agriculture	6	6.98
	Daily wage labour	1	1.16
	Salaried employee	4	4.65
	Unemployed	31	36.05
	House wife	43	50
Household annual income	< 10000	74	86.05
	10000-50000	3	3.49
	50001-100000	5	5.81
	> 100000	4	4.65
Sanitary facility	Yes	5	5.8
	No	81	94.2
Electricity	Yes	71	82.5
	No	15	17.5
Communication	Yes	69	80.2
	No	17	19.8
Alcohol	Yes	14	16.28
	No	72	83.72
Tobacco	Yes	21	24.42
	No	65	75.58
Smoking	Yes	0	0
	No	86	100
Health condition	Normal health	38	44.19
	Non-communicable disease	48	55.81

2.7 Ethics approval and consent to participate

Ethical approval for this study was obtained from the Ethical Review Committee of Department of Anthropology, Central University of Odisha, Koraput district of Odisha. Before collecting data, all objectives of the study were discussed with selected participants, their consent was obtained and they were given the choice to remain or opt out if they feel uncomfortable.

2.8 Statistics applied

Descriptive statistics was used to find the *mean* and *standard deviation*; whereas *Chi-square* was used to test for association between two categorical variables, *t-test* was used to compare the averages of two separate groups, *and Correlation Coefficient* was used to measure the strength of a linear association between two variables. Finally, *Phi Coefficient* measures the association between two dichotomous variables and *Cramer's V* measured how strongly two fields are associated.

3. RESULTS

This study investigated the quality of life among 86 women from a small village in Sadar block of Keonjhar district, Odisha. Field-based primary data were gathered, processed, tabulated, analysed and the findings were objectively examined.

A total of 86 participants were studied and out of which 38 (44.19%) were in normal health condition while 48 (55.81%) were having infirmity condition. Four domains of quality of life i.e. physical, psychological, social, and environmental; which were scored with concerned to normal and infirmity conditions. And it was resulted that, females with normal health condition showed better quality of life as compared to the

Infirmity condition (*Table 2*). *Two-tailed t-test* was calculated to compare the average scores of each domain of quality of life to understand that whether the relation between them is by any chance or it is true significantly. *Table 2* shows that, individuals with good health showed good quality of life and individuals with bad health showed bad quality of life. Some statistical tests were performed to check the relationship between health status and health condition of the studied respondents, like *Chi-square test* (x^2) to test the hypothesis and *Phi Coefficient* (ø) to establish the link between the variables.

Table 2: Measure the relation between health status and quality of life

| Health condition | Control | | Case | | p value for |
Quality of life	(n=38)	SD (±)	(n=48)	SD (±)	t-test
Physical	88.26	9.08	67.63	23.38	**< 0.001**[**]
Psychological	77.24	11.72	56.6	21.6	**< 0.001**[**]
Social	59.11	12.17	46.98	24.16	**0.006**[**]
Environmental	44.92	7.78	33.71	17.85	**0.005**[**]
Average QoL	**66.6**		**58.85**		

[**]*P value significant at < .01*

Table 2.1 shows the result of the *Pearson Chi-square test* where the score of *Chi-square* is 18.36, degree of freedom is 1 along with *p-value* < .0001, indicating a degree of significantly less than 1%. If the *p-value* is less than .05, the null hypothesis is rejected and the alternative hypothesis is accepted. So, it can be inferred that there is a link between health condition and respondents' quality of life.

Table 2.1: Analysis of *Pearson Chi-square test*

Pearson Chi-square value	D.F	P-value
18.36	1	**< .0001**[**]

[*]P value significant at < .01

Table 2.2 shows the result of *Phi* and *Cramer's V*. The value of *Phi* and *Cramer's V* is .49, more than 0.25. These test are done to test the reliability and validity of the output so that the research can be more robust. The rule says that, the value of *Phi* and *Cramer's V* ranges from 0 to 1. Ranges such as, in 0 to 0.05, relationship is very weak or zero relation; in 0.05 to 0.1 relationship is weak; in 0.10 to 0.15 results into moderate relationship, 0.15 to 0.25 results into strong relationship and greater than 0.25 results into very strong relationship between the variables.[14] So, according to the rule the association of the variables show a very strong relationship between the variables.

Table 2.2: Result of *Phi* (ø) and *Cramer's V*

Nominal by Nominal	Value	P-value
Phi	0.49	**< .00001**[**]
Cramer's V	0.49	**< .00001**[**]

[*]P value significant at < .01

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[14] Akoglu, H. (2018). User's guide to correlation coefficients. *Turkish Journal of Emergency Medicine.* Pp 91-93. https://doi.org/10.1016/j.tjem.2018.08.001

32 women (37.2%) admitted about their consuming intoxicants and remaining 54 (62.8%) were not consuming. Domain scores of quality of life among the consuming individuals and non-consuming individuals was calculated, which resulted that those who were consuming intoxicants possessed bad quality of life and those who were not consuming possessed good quality of life (*Table 3*). *Two-tailed t-test* was calculated to find out whether the relation between them is by any chance or it is true significantly. *Table 3* shows that the individuals not consuming any toxic substances showed good quality of life as compared to the individuals consuming it.

Table 3: Measure the relationship between consumption of intoxicant and health status

Consumption of intoxicants	**Yes (n= 32)**	**SD (±)**	**No (n= 54)**	**SD (±)**	**p value for t-test**
Quality of life					
Physical	69.78	21.69	80.87	20.48	**0.017458**[*]
Psychological	58.31	21.2	70.11	20.24	**0.009392**[**]
Social	46.21	21.2	55.96	20.44	**0.033067**[*]
Environmental	34.78	15.69	40.96	15.14	0.069737
Average QoL	**52.27**		**61.98**		

[*]***P value significant at < .05***

[**]***P value significant at < .01***

Table 3.1 shows the result of the *Pearson Chi-square test* where the score of *Chi-square* is 11.9933, degree of freedom is 1 along with *p-value* .0005, indicating a degree of significantly less than 1%. If the *p-value* is less than .05, the null hypothesis

is rejected and the alternative hypothesis is accepted. So, it can be inferred that there is a link between consumption of intoxicants and respondents' quality of life.

Table 3.1: Analysis of *Pearson's Chi-square test* (x^2)

Pearson Chi-square value	D.F	P-value
11.9933	1	.0005[**]

***P value significant at < .01**

Table 3.2 shows the value of *Pearson Correlation Coefficient* to be -.37 with *p- value* .0003, which means there is a negative association between the variables. *R value* ranges from -1 to 1 and closest to 0 is found to have weak association among the variables. In case of negative association, if one variable increases then the other variable decreases.

Table 3.2: Result of *Pearson Correlation Coefficient test* (r)

Pearson Correlation	Value	P-value
R	-.37	.0003[**]

***P value significant at < .01**

87.2% married women and 12.8% widow women were scored for their quality of life. Mean score of four domains of quality of life among the participants showed that, average score of married women is greater than the average score of widow women (*Table 4*). *Two-tailed t-test* was calculated to compare the mean score of each domain of quality of life to understand that whether the relation between them is by any chance or it is true significantly. In *Table 4*, physical, psychological, and social

domain scores are statistically significant at $p< .01$; while environmental domain is significant at $p< .05$.

Table 4: Measure the relation between marital status and quality of life

Marital status	Married		Widow		p value for
		SD (±)		SD (±)	
Quality of life	**(n=75)**		**(n=11)**		**t-test**
Physical	79.46	20.96	58.18	22.68	**< .01****
Psychological	68.34	20.47	47.81	21.99	**< .01****
Social	55.52	20.47	30.63	22.41	**< .01****
Environmental	39.92	15.2	30.09	15.29	**< .05***
Average QoL	**60.81**		**41.67**		

***P value significant at < .05**

****P value significant at < .01**

Table 4.1 shows the result of the *Pearson Chi-square test* where the score of *Chi-square* is 11.5238, degree of freedom is 1 along with *p-value* .0006, indicating a degree of significantly less than 1%. If the *p-value* is less than .05, the null hypothesis is rejected and the alternative hypothesis is accepted. So, it can be inferred that there is a link between marital status and respondents' quality of life.

Table 4.1: Analysis of *Pearson Chi-square test*

Pearson Chi-square value	D.F	P-value
11.5238	1	**.0006****

****P value significant at < .01**

Table 4.2 shows the result of *Phi* and *Cramer's V*. The value of *Phi* and *Cramer's V* is 0.37, more than 0.25. So, according to the rule the association of the variables show a very strong relationship between the variables.

Table 4.2: Result of *Phi (ø)* and *Cramer's V*

Nominal by Nominal	Value	P-value
Phi	0.37	**.0006***
Cramer's V	0.37	**.0006***

*****P value significant at < .01**

Table 5 shows the mean value of quality of life of participants those who believe in superstitious practices. Women believing in superstitious practices (63.95%) possessed a little bad quality of life as compared to the women not believing (36.05%) in superstitious practices.

Table 5: Measure the relation between superstitious belief and quality of life

Belief in superstitious practices	Yes	SD (±)	No	SD (±)	p value for t-test
Quality of life	**(n= 55)**		**(n= 31)**		
Physical	74.25	20.67	81.16	22.06	.1456
Psychological	62.9	19.51	70.7	20.45	.0917
Social	47.67	21.42	60.61	21.77	**.0044****
Environmental	35.49	15.12	44.29	15.27	**.0095****
Average QoL	**55.07**		**64.19**		

****P value is significant at < .01**

Table 5.1 shows the analysis of the *Pearson Chi-square test* where the score of *Chi-square* is 5.0075, degree of freedom is 1 along with *p-value* .025, indicating a degree of significantly less than 5%. If the *p-value* is less than .05, the null hypothesis is rejected and the alternative hypothesis is accepted. So, it can be inferred that there is a relationship between the variables.

Table 5.1: Analysis of *Pearson Chi-square test*

Pearson Chi-square value	D.F	P-value
5.0075	1	**.025***

P value significant at < .05

Table 5.2 shows the value of *Pearson Correlation Coefficient* to be -.24 with *p- value* .025, which technically means there is a negative weak association between the variables. *R value* ranges from -1 to 1 and closest to 0 is found to have a weak association among the variables. In case of negative association, if one variable increases then the other one decreases.

Table 5.2: Result of *Pearson Correlation Coefficient test* (r)

Pearson Correlation	Value	P-value
R	-.24	**.025***

P value significant at < .05

Table 6 shows the mode of treatment viz. modern and traditional methods taken by the participants. Of 86 individuals, 45.34% women prefer modern treatment while 54.66% women prefer traditional treatment. Modern treatment has resulted into good

quality of life of respondents' as compared to the traditional method of treatment. Average score of social and environmental domains are significantly maximum in case of modern treatment followed by traditional treatment; whereas the average score of physical and psychological domains are not significantly larger in modern method.

Table 6: Measure the relationship between mode of treatment and respondents' quality of life

Mode of treatment	Modern	SD (±)	Traditional	SD (±)	p value for t-test
Quality of life	(n=39)		(n=47)		
Physical	81.33	22.06	72.93	20.67	.0655
Psychological	69.38	20.45	62.68	19.51	.1336
Social	59.23	21.77	46.61	21.42	**.004**[**]
Environmental	42.92	15.27	35.12	15.12	**.0176**[*]
Average QoL	**63.21**		**54.33**		

[*]**Significant at p< .05**

[**]**Significant at p< .01**

Table 6.1 shows the result of the *Pearson Chi-square test* where the score of *Chi-square* is 4.3541, degree of freedom is 1 along with *p-value* .0369, indicating a degree of significantly less than 5%. If the *p-value* is less than .05, the null hypothesis is rejected

and the alternative hypothesis is accepted. So, it can be inferred that there is a link between mode of treatment and respondents' quality of life.

Table 6.1: Result of *Pearson Chi-square test*

Pearson Chi-square value	D.F	P-value
4.3541	1	**.0369**[*]

[*]***P value significant at < .05***

Table 6.2 shows the result of *Phi* and *Cramer's V*. The value of *Phi* and *Cramer's V* is 0.23, less than 0.25. So, according to the rule the association of the variables show a strong relationship between the variables.

Table 6.2: Result of *Phi (ø)* and *Cramer's V*

Nominal by Nominal	Value	P-value
Phi	0.23	**.0369**[*]
Cramer's V	0.23	**.0369**[*]

[*]***P value significant at < .05***

4. DISCUSSION

In this study, the key objective was to unveil the impact of culture on quality of life of women of *Munda* community, and this study was conducted among 86 individuals randomly selected from the study universe of Keonjhar district in Odisha. This study with the help of WHOQOL-BREF questionnaire, structured interviews and Focus Group Discussion helped in unearthing the facts about women health. It encompasses their prior health status, substance abusing, marital status, their belief or perception regarding superstitious practices especially when they are sick, and significantly about their mode of treatment at the time emergency or outbreak of any infirmity.

Impact of culture on women's Quality of Life

It is found that culture has significantly influenced the quality of life among the population of women. Culture is a set of rules and norms being followed by the people to achieve the salvation in accordance to keeping themselves disease-free and seeking healthcare properties. In this study, culture in form of their belief system has played the most significant role where it is found that some believes in superstitious practices being blind-folded and some do not; whereas in common all follow certain sort of belief system. When it is about health and disease, accessing the proper medical system to achieve a good health is no more a sin to them, yet some do not find the way to trust on the modern mode of treatment to cure themselves. Resulting which they suffer from severe infirmity with gradual time and ultimately they strongly believe that bad health is caused due to some bad sins committed by them. Therefore, to them cultural belief system has persuaded them to pursue magical practices or any blind superstitions instead of visiting doctors at the time of emergency.

Quality of Life of women with regard to their health status

An intense investigation was done among the women regarding their health status and quality of life lived by them, which resulted that disease-free people (n=38) had significantly good quality of life (P< .01) than the people with infirmity condition (n=48). There was a positive association which showed a direct relation between the health status and their quality of life (ø=.49). Burckhardt and Jones (2005) had made a similar study[15] among the women with age ≥ 18 (with regional pain and widespread

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[15] Burckhardt, C.S., and Jones, K.D. (2005). Effects of chronic widespread pain on the health status and quality of life of women after breast cancer surgery. *Health and Quality of Life Outcomes, Vol 3*, Issue 1, Pp 1-8. https://doi.org/10.118.1477-7525-3-30

pain) was carried out to record their quality of life after their breast cancer surgery, which showed that there was no statistical significance in their result of bearing the pain, even though the quality of life among the individuals with widespread pain scored lower than the regional pain individuals. In 2019, a study[16] was done to predict the quality of life among the women with Fibromyalgia, which showed a significantly lower quality of life than their healthy counterparts.

Quality of Life of women with regard to consumption of intoxicants

It is also a matter of great concern that the individuals (n=32, 37.2%) who consumed toxic substances like alcohol, smoking, or chewing tobacco frequently had poor quality of life. This study resulted on average that women (n=54, 62.8%) not consuming intoxicants had significantly better quality of life (P< .05) in physical and psychological domains than the consuming individuals. But their social and environmental domains are not significantly greater than the latter one, as some people argued that consuming intoxicants does not harm their lives proving this by the period of time they have been consuming, which according to them gives mental peace and strength to work productively. So far the fact is concerned about consuming *Handia* (rice beer) on empty stomach resulted to be much fatal yet some believed it to be beneficial and claimed that it contains no harmful substances. If people would consume intoxicants on a regular basis with earning low wages or zero wages (i.e.

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[16] Sampere-Rubio, N.., Aguilar-Rodriguez, M., Ingles, M., Izquierdo-Alventosa, R., & Serra-Ano, P. (2019). Physical condition factors that predict a better quality of life in women with fibromyalgia. *International Journal of Environmental Research and Public Health, Vol 16,* Issue 17. https://doi.org/10.3390/ijerph16173173

housewives), this would definitely disrupt or sabotage their livelihood. They have to be made aware of the knowledge related to their health and quality of life.

Quality of Life of women with regard to their marital status

Women have multiple roles to play in the society. In this study quality of life of married women (n=75) resulted to be significantly (P< .01) better in physical, psychological, and social domains than the widow women (n=11); but their environmental domain of married group is not significantly better than the latter one; contributing to the facts that widows were helpless with lack of financial resources, challenging physical safety and security and even though some were trying to cope but due to poor health and social care, they were the suppressed group. Another study among the married women and housewives conducted by Ahmad and Khan (2018) using WHOQOL-BREF (1996) resulted that, there was no significant differences in the physical domain but there was a significant difference in psychological, social, and environmental domains. But, Janke *et al.* (2017) has found in his study[17] that widows benefited from increased involvement in some activities while this was not necessarily the case for married women.

Quality of life of women with regard to their beliefs and mode of treatment

"Health is wealth" quoted by American Philosopher *Ralph Waldo Emerson* in 1860. He knew then that health is the real wealth, which nowadays people are ill-treating. Indigenous people rely on traditional method of treatment (n=47, 54.66%) and strongly believe in superstitious activities (n=55, 64%) to cure themselves and prefer

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[17] Janke, M.C., Nimrod, G., & Kleiber, D.A. (2017). Leisure Activity and Depressive Symptoms of Widowed and Married Women in Later Life. *Journal of Leisure Research, Vol 40,* Issue 2. https://doi.org/10.1080/00222216.2008.11950140

to take the patient to a witchcraft instead of doctors, which makes the modern method of treatment (n=39, 45.34%) weaker and hopeless. Some women (n=47) argued that modern treatment is not safe at all, they cut the organs and the medicines prescribed by them puts them into an uneasy mode. Instead, they go to witchcraft and get their problems solved. On the other hand, few participants supported the modern medical treatment and do not believe in superstitious practices (n=31, 36%), whose income is good and literate enough to distinguish between the blind-folded facts and the scientifically proven facts. It is all about believes the people have developed within themselves. In this study, quality of life of respondents not believing in superstitious practices and opting for modern method of treatment is significantly (P< .05) greater than the respondents believing in superstitious practices and choosing traditional method of treatment.

5.   STRENGTH AND LIMITATIONS OF THE STUDY

The major strength of this study is that, it is the first study among the women of *Munda community* of Sadar block of Keonjhar district, Odisha; which has dealt with the impact of culture on quality of life among the normal individuals and individuals with certain infirmity. However, the major limitation of this study is its cross-sectional design. Also it was confined to a small geographical area and only a few socio-economic and demographic variables have been considered.

6.   CONCLUSION

Quality of life (QoL) is an individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, exceptions, standards, and concerns (*World Health Organisation*). A good

quality of life can have a positive impact on physical and mental health, productivity, and social relationships; whereas a poor quality of life can lead to negative outcomes. It seems to be a complex outcome as it gets affected due to several comorbidities. In this study culture has significantly put impact on the women's quality of life.

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