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Personal Perception of Health in Urban Women of Low Socioeconomic Status: A Qualitative Study

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Abstract

Introduction: Women of low socioeconomic status experience health disparities that contribute to poor outcomes. **Objectives:** The purpose of this study was to explore self-perception of health and health promoting behaviors in women who were patients in a federally qualified health center. **Methods:** A qualitative descriptive design was used to interview 19 women. The researchers conducted content analysis and used descriptive statistics to present participant demographics. **Results:** Women viewed health primarily as physical and themselves as *healthy, in-between healthy and unhealthy*, or *unhealthy*. *Healthy* women made more active attempts to improve their health, while *not healthy* women reported twice as many barriers to health maintenance and felt defined by their illnesses. **Conclusion:** Findings support that a women's self-perception of health is aligned with self-management health behaviors and health outcomes.

Keywords

women's health, health status, health behavior, underserved communities, self-management, qualitative methods

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Introduction

Women who experience low income, along with other indicators of socioeconomic status (SES) such as educational level, geographic location, and opportunity for employment, are at high risk for health disparities.[1] For instance, women of low SES are more likely to be obese, report more depressive symptoms, receive fewer preventive screenings, and die prematurely than women of higher SES.[2-7]

Self-perception of health is an important factor associated with patient outcomes, including quality of life, mental health, and physical health.[8-11] Chronic conditions including cancer, diabetes, and heart disease contribute to a lower self-perception of health compared to those without chronic conditions.[8,9,12] Economic status is associated with perception of health, with a greater income linked to a higher self-perception of health.[9] Psychological factors, including stress, have an inverse relationship with self-perception of health.[9] Additionally, higher self-perception of health contributes to increased willingness to participate in interventions aimed to improve outcomes.[13]

Many studies have explored self-perception of health, associated health outcomes, and health promoting behaviors in different populations.[8-13] However, there is a gap in the literature regarding this experience specifically in women of low SES. It is important to explore this experience in order to improve health outcomes and reduce disparities in this population. Thus, the purpose of this study was to explore self-perception of health and health promoting behaviors in a sample of urban women experiencing low SES. A federally qualified health center (FQHC), whose mission is to provide primary care and other health services to uninsured, underinsured, and other low-income individuals and families was identified as an ideal site at which to invite women of low SES to participate in the study.[14]

Methods

Research Design and Setting

This qualitative descriptive study was conducted with participants who were enrolled as patients at a FQHC in Florida that serves a low-income, urban, and diverse population. Inclusion criteria, selected to achieve a broad demographic sample of women experiencing low SES with varying perceptions of health, included the following: 18 years of

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age and older, not pregnant at the time of the interview, and able to speak and read either English or Spanish. The university institutional review board approved this study.

Study Procedures and Data Collection

Participants were recruited using flyers in English and Spanish placed in prominent areas within the clinic and distributed by staff members at the time of a patient encounter. Interested women were screened for eligibility and given a written and verbal explanation of the study in their language of choice

Participants completed a demographic and health status questionnaire prior to a one-on-one semistructured interview conducted in a private room at the clinic. Interviews included questions about their perception of health and being healthy, their personal definition of health, and barriers and facilitators encountered to being healthy. Open-ended questions included in the interviews were developed from the literature and pilot-tested and refined prior to data collection. Interviews were conducted over a three-week period on preplanned days when private space was available in the FQHC. Interviews were conducted by 2 research assistants, one of whom was fluent in both Spanish and English, who were trained in qualitative interview techniques by the principal investigator. There were 17 interviews conducted in English and 2 in Spanish. No names or personal identifiers were collected. Participants received $50 gift cards to a popular local retailer once the interviews were complete.

Data Analysis

Interviews were professionally transcribed. Directed content analysis was used to code and generate themes from the data as literature suggests that perception of health affects health behaviors; we wanted to further understand this phenomenon in low-income women.[15] A minimum of 2 research team members individually read each interview and coded relevant statements. The team members met to compare codes and came to consensus on identified codes for each interview. The larger group met to discuss the emerging codes each team developed and discussed emerging themes. Codes were placed into a comprehensive Microsoft Excel spreadsheet and commonalities were assessed among participants. This codebook was used by all teams for coding subsequent transcriptions. Descriptive statistics were used to present the demographic data collected from questionnaires.

Results

Nineteen women participated. Interviews ranged in length from 35 minutes to over 1 hour. Most participants were African American between the ages of 18 and 79 years, of very low income, and insured by Medicaid. Most were overweight or obese (63%) and suffered significant chronic illness. Table 1 presents participants' demographic characteristics.

Table 1. Participant Demographics (n = 19).

Demographic	n
Age (years)	
18-29	4
30-45	8
46-64	5
65-79	2
Race	
African American	14
Caucasian	4
American Indian or Alaska Native	1
Hispanic/Latino[a]	
Hispanic/Latino	1
Not Hispanic/Latino	17
Insurance coverage	
None	3
Medicaid	11
Medicare	1
Both Medicaid and Medicare	3
Private insurance	2
Yearly income ($)	
<15 999	14
16 000-24 999	3
25 000-34 999	2
Health conditions	
Hypertension	9
Hyperlipidemia	6
Diabetes	1
Depression	5
Anxiety	5
Educational level	
Some high school	2
High school diploma/GED	11
Some college or 2-year degree	6

[a]Not all of participants answered the question.

Women's responses grouped into three straightforward categories based on their self-perception of health. The women described themselves as *healthy* (n = 6), *in-between healthy and not healthy* (n = 5), and *not healthy* (n = 8). Health was generally defined by participants as having to do with diet and exercise, but self-perceived healthy women included more global terms that addressed psychosocial and spiritual components of health. Participants generally knew what it took to be healthy, but women described different behaviors toward achieving or maintaining health that were aligned with their personal perception of their own health.

Women's Self-Perceptions of Health

Women Who Perceived Self as Healthy. Self-perceived *healthy* women felt that they were in control of their own health and actions. Despite having few resources and living in less than ideal situations, *healthy* women maintained healthy practices to the best of their ability. One self-perceived *healthy* woman explained, "I consider myself healthy because I keep myself up . . . I make sure I do the right thing." Though most of the *healthy* women had a chronic illness, they made active efforts to manage these conditions. Another self-perceived *healthy* woman said that "physically, I have a lot of work to do. As you can tell, I'm grossly overweight, and I'm working on that . . . but now I'm makin' a conscious effort to lose the weight and everything else." The physical improvement *healthy* women with chronic conditions showed over time encouraged them to view themselves in a positive light and was a gauge of feeling healthy. One woman who felt healthy stated, "I'm always gonna require oxygen, but where I was to where I am now is a big improvement, a vast difference."

Although physical well-being was a large part of *healthy* women's definition of health, this group viewed health to be more holistic and encompassing of spiritual, psychological, and psychosocial well-being compared with other subgroups. Physical health was defined by *healthy* women as eating well and doing some form of activity (such as walking or dancing). Though many women did not have ideal physical health, some felt if they at least had the nonphysical aspects of their life under control, they were healthy. For instance, one *healthy* woman said, ". . . my overall health is not just based on my physicalism, but my mental and my spiritual well-being. If I have two out of three, I'm in a good place."

Though women self-perceived themselves as *healthy*, they still had at least one comorbidity each. There were a total of 11 comorbidities in this group. Hypertension was the most common, followed by heart condition, anxiety, hyperlipidemia, thyroid issues, and pulmonary arterial hypertension. Only one *healthy* woman self-reported that she currently smoked. With regard to body mass index, 17% of women were overweight and 50% were obese.

Women Who Perceived Themselves as In-Between Healthy and Unhealthy. This *in-between* group felt that although they had medical issues, they still had "good days." *In-between* women were aware of what needed to be done in order to fully become healthy, but they did not consistently take action to do so. One woman attributed her in-between health status to a recent diagnosis of pre-diabetes. She was hoping to work toward being healthy because her pre-diabetic diagnosis was "waking up the part of me that knows now I have to do what I need to do if I want to live life without more medication." Women also felt that though they may have previously been healthy, they no longer had the same capabilities and/or health habits that once made them feel healthy. Lack of an appropriate diet was a common concern among this subgroup.

Physical health was defined by most *in-between* women as being a healthy weight and having no physical limitations to stop them from fully living their lives. A woman who had an in between status felt physical health was important, but at the same time she considered her physical health as a reason why she was not healthier. She stated physical health was important "to live life longer and be able to do more than what you're doing," but then added "I could do more than what I do, if I was more healthier."

Although women self-perceived themselves as *in-between* healthy and unhealthy, they only had a total of 4 comorbidities in the group. These included hypertension, hyperlipidemia, diabetes mellitus, and hidradenitis. Only 1 woman self-reported smoking. Regarding body mass index, 40% of *in-between* women were overweight and 20% were obese.

Women Who Perceived Themselves as Unhealthy. Another group of women described themselves as *not healthy.* They felt defined by their health conditions and medications they were taking. They did not feel in control of their lives and often felt consumed with taking care of others rather than themselves. One of the primary differences between this group and others was the lack of self-prioritization and self-care. One *not healthy* woman emphasized this lack of self-prioritization when she said health "is important, but it's not on the front burner. It's not something that I wake up every morning like, 'Oh, I got to eat healthy.' No."

Not healthy women had twice the number of comorbidities as *healthy* women; most commonly hypertension and hyperlipidemia. A *not healthy* woman spoke of how she felt consumed by her illnesses as she said "I think my weight is the problem . . . I have high cholesterol, I'm borderline with diabetes. Sometimes my pressure goes up and down and so they think . . . if I could lose about 80 pounds, then I'll be a healthier me."

Not surprisingly, self-reported rates of depression and anxiety were higher in the *not healthy* group compared with others. Over half of those who perceived themselves as *not healthy* stated they had depression. Depression often hindered women from achieving adequate health, as one woman explained "depression . . . it just makes you tired and so I'm going through a lot right now." Health was often defined in this group as purely physical and simplistic. Inadequate physical health coincided with difficulty achieving basic needs such as proper nutrition, health care, and exercise. A *not healthy* woman said, "No, ma'am. I'm not a healthy person, 'cause I don't exercise as properly as I'm supposed to, and I don't eat right."

The negative self-perceived health status of these women seemed to coincide with their current health status, as *not healthy* women had a collective total of 22 comorbidities. Depression was the most common comorbidity that 63% of women had, followed by hypertension (50%), hyperlipidemia (50%), and anxiety (38%). Less common comorbidities that 13% of participants had included posttraumatic stress disorder, stroke, back pain, heart conditions, thyroid issues, and some sort of "other" condition. One-fourth of women were active smokers. Most participants were overweight (13%) or obese (50%).

Barriers to Achieving Adequate Health

Despite varying perceptions of personal health, women faced similar barriers to achieving adequate health. However, barriers to maintaining health were perceived as more limiting and challenging to women who considered themselves unhealthy. Women who considered themselves healthy were able to overcome the barrier and make healthy behaviors work for them.

Environmental Considerations. The environment in which each woman lived played a big role in healthy behaviors. Women in all groups discussed walking as their main form of exercise. However, women who considered themselves *healthy* seemed to have or create more opportunities to walk and engage in other forms of physical activity such as yoga, Zumba, dance, and even exercising in their living room if their environment was not conducive to being outside. *Not healthy* women described many environmental barriers to being physically active that included weather, safe environments in which to exercise, and lack of gym access.

Another environmental barrier for many women was accessibility to affordable grocery stores and the cost of eating a healthy diet. Regardless, nearly all the women described trying to incorporate healthy foods into their diets, though some were more successful than others.

Physical Considerations. *Healthy* women spoke more positively of their physical health and did not identify as many physical barriers to being healthy as *not healthy* women did. Fatigue was experienced by all groups, but it was perceived as more of a constraint and challenge for women who felt they were unhealthy. *Not healthy* women also talked about pain, medication, and physical limitations that prevented them from becoming active.

Social Considerations. A social barrier described by nearly all women was the difficulty of caring for themselves due to responsibilities as caregivers for both children and other loved ones. All groups put their family members ahead of themselves, and thus their personal health suffered. Some women spoke of families who did not support them in making positive changes in their health behaviors, especially when it came to changes in diet. This made it difficult for some women to cook and prepare foods the way they wanted to be healthy.

Psychological Considerations. Psychological barriers to health behaviors were also prevalent. Stress was one of the most common barriers that women faced daily; this sometimes affected their desire to engage in healthy behaviors. Lack of ability or opportunity to cope with this stress was potentially why several women viewed themselves as *not healthy*. Most women knew there were ways of coping with stress, but *healthy* women described the actual behaviors that they used to cope such as meditation, prayer, and listening to music. *In-between healthy and not healthy* women and *not healthy* women tended to talk more about their intentions rather than describe actions they had taken to cope. Several women also struggled with depression and anxiety, which made it challenging to maintain their health. Table 2 provides exemplar quotes from participants regarding barriers to health promoting behaviors.

Discussion

The results of this study suggest that positive self-perception of health was aligned with more positive health behaviors and ultimately better health outcomes, even in the face of chronic illness. Mind-set, for these women, was powerful. Supporting literature shows that those with a decreased self-perception of health had a greater number of medical conditions.[11] Women in our study were consistent with these findings, as those who perceived themselves as *not healthy* had the greatest number of comorbidities. Further, these conditions especially burdened the *not healthy* women, making them feel defined by their illnesses.

In our study, personal perception of health affected certain health behaviors. *Healthy* women made greater active and successful attempts at maintaining a healthy lifestyle, particularly regarding exercise, diet, and weight. They knew what it took to be healthy and engaged in actions to make healthy behaviors happen in their lives. They could see benefits from pursuit of healthy behaviors and found even the smallest improvement in health to be motivating. Women who viewed themselves as *unhealthy* or *in-between* had the opposite view and were mired down in their illnesses, affecting their motivation. Even personal perception of health behaviors can be an impactful determinant to health outcomes. One study found a negative self-perception of physical activity was associated with increased psychosomatic health complaints, which has important implications for well-being and quality of life in individuals.[16]

While women viewed health primarily as physical well-being, they frequently mentioned stressors and other psychological challenges they encountered, such as anxiety and

Table 2. Exemplar Quotes of Barriers to Health.

Barriers to health	Exemplar quote
Environmental/resource barriers	
Affordability	"It costs more to eat healthier, because to buy vegetables and fruits I think are very expensive compared to buying frozen foods or foods that are processed . . ."
	"Sometimes I wish I could afford to go to the gym . . . then, I would get more different options when working out, instead of just walking and stuff. I mean, it has been a thought."
Weather	"When the weather is like 90-some degrees. That make it hard for me to wanna get up and get out and go for a walk."
Living situation	"I lock myself in the house and I let the world fall apart around me."
Food choices	"Yeah, my blood pressure probably up, because I had pork last night, and I shouldn't have ate it."
Physical barriers	
Fatigue	"When I work, I literally sometimes don't even get a break to where I can sit down and eat."
Pain/discomfort	"For as long as I can remember, I've always had pain."
Psychosocial barriers	
Lack of support	"Remember? Look at me, I don't have no support.
	"That's the biggest part of my stress, like drop him here, pick him there, drop these kids here. I sometimes feel like a machine. The biggest part of it is, is getting some help, so I can have more time for me."
Psychological barriers	
Depression	"Pretty much that is my problem right now, is just depression."
Lack of motivation	"I don't have anybody who would motivate me . . ."
Lack of self-care	"I have to first realize that I was usin' food to punish myself."
	"I know my health status is just again my unwillingness to put me first."
	"I don't have time to take care of myself."

depression. Many of the women, particularly those who viewed themselves as *not healthy*, experienced profound stress in their lives. This was often attributed to their role as caregiver for their family and the responsibilities associated with that role. Family caregivers often experience chronic stress resulting from their role.[17] Depression and anxiety rates were also notably higher in the *not healthy* group compared with those who were *healthy* and *in-between*. Those who viewed self as *healthy* had a more holistic definition of health and described using their resources to handle life stressors. Other studies had comparable findings, as women with higher self-perceived levels of stress had a significantly lower health-related quality of life.[18] Another study found those who had increased depression and anxiety had lower perceived physical health.[19]

We found those who viewed themselves as *not healthy* chose or were economically unable to eat healthy foods less often than *healthy* women and did not make as many active attempts to lose weight. Women who perceived themselves as *not healthy* viewed exercise as something that was a planned event, such as a visit to a gym, and not necessarily part of daily life. Self-perceived *healthy* women were better able to capitalize on daily life activities to improve diet and exercise.

Social support may also be beneficial to physical health, as social support used as an intervention provided motivation to exercise among free clinic female patients.[20] We found that self-perceived *not healthy* women often described lack of motivation to exercise and eat properly, and that *in-between healthy and unhealthy* women were more inconsistent in their attempted healthy behaviors.

Studies also show that social support is an important determinant of self-perceived and actual health status.[21,22] While social support from family was integral, we found that women often did not have this and felt that support from peers and health care providers could be just as impactful. Providers can help women integrate small, achievable goals, particularly for those who feel *in between healthy* and *unhealthy*. This group may be open to taking the next steps to incorporate more healthy actions into their daily lives. For those who feel *unhealthy*, providers can explore ways to help women gain control in their lives and support changes in thinking about actions they can take to improve and manage their health even within the constraints of chronic illness. Providers may also be able to guide self-perceived *unhealthy* women toward a broader view of bio-psychosocial health.

Future research is needed to determine how to further support women who have a negative self-perception of health. Interventions that incorporate and build on women's personal perceptions of health can potentially empower and improve women's success in changing health behaviors. Those with a lower self-related perception of health use community agencies more frequently,[11] emphasizing the importance of agencies (such as FQHCs) in positively impacting a patient's personal outlook on health.

Conclusion

Findings from our study suggest a higher self-perception of health may positively be linked with more active attempts to improve or maintain health status in this group of urban women experiencing low SES. Further research should aim to develop and test community-based and in-clinic interventions to improve self-perceived health status and empower women to take positive steps toward improving their own health. Continued policy support for centers, such as FQHCs, designed specifically to provide access to care for low income individuals, is foundational in reducing health disparities. Last, providers should maximize their impact on patient outcomes by actively supporting and influencing health perception in women of low SES.

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