Gender, caste, class, and health care access
Experiences of rural households in Koppal district, Karnataka

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Preparatory phase:

Pre-survey research meetings: Gita Sen, Paul Jacob, Aditi Iyer, Asha George

Focus group discussions: Vani Periodi, Anita Gurumurthy

Sample selection:

Design of sampling strategy & frame: Paul Jacob

Creation of sampling frame & selection of households: Asha George, Aditi Iyer, Paul Jacob

Creation of address book: Randesh at IT for Change

Backup support: Gurumurthy Kashinath and Randesh at IT for Change

Interview schedule:

Design: Aditi Iyer, Paul Jacob, Gita Sen, Asha George

Design review: Margaret Whitehead, Sunil Nandraj

Translation: Anita Gurumurthy, Sowbhagyavathi, Venkatesh Murthy, Lakshminarayan

Kannada typing: Uma, Geetha Raghunathan, Lakshminarayan Rao, Nagaratna

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Training and pilot testing (first round):

Trainers: Shaibya Saldanha; MS Venkatesh Murthy, B. Lakshminarayan, Sowbhagyavati

Interviewees: Sangha women visiting Koppal; Sangha women and their families at Naregal

Training and pilot testing (second round):

Training design (away from the field): Umashankar Periodi

Training design & implementation in the field: Amrutha, Aditi Iyer, Asha George, B. Lakshminarayan, M.S. Venkatesh Murthy

Interviewees: Sangha women and their families at Allahnagar

Data collection

Supervision of research team: Aditi Iyer, Asha George, M.S. Venkatesh Murthy, B. Lakshminarayan

Logistics management: Asha George, Aditi Iyer with Uma, Shankaramma M., Renuka K., Parasuram, Bheemanna

Interviewers:

The women (in alphabetical order): Kusuma, Lalitha, Laxmi, Laxmibai, Manjuladevi, Nagaratna, Neelamma, Renuka, Rudramma, Sampatkumari, Shankaramma P., Uma, Vijayalaxmi.

The men (in alphabetical order): Devendrappa, Mahadevappa, Mounesh, Pradeep, Ramesh, Sanneappa, Sharanappa G., Sharanappa, Veerappa, Yallappa D., Yallappa, Yankangowda.

Post data collection

Scrutiny programme:

Design: Aditi Iyer

Design review and editing: Asha George

Scrutiny team: H.S. Veena, M.S, Venkatesh Murthy, V.R.N. Sharma, Bhaskar Achar

Compilation of qualitative notes:

Field notes: Asha George, Aditi Iyer

Translation of additional qualitative information in the interview schedules: Scrutiny team

Typing: Lita Mishra

Illness descriptions: Aditi Iyer, Soumya B.V. building on summarised descriptions by the scrutiny team

Database design:

Aditi Iyer, with inputs from Ashish Kumar, Chandan Mukherjee and Prof. Nagdevara

Data entry:

Supervision of data entry operators: Aditi Iyer, Soumya B.V.

Data entry operators: Datamation Consultants Pvt. Ltd.

Quality checks (20 per cent sample): Aditi Iyer, Soumya B.V. with inputs from Chandan Mukherjee

Post-data entry validity checks & completion of database:

Aditi Iyer, Soumya B.V.

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With the field research team for the Health Provider Survey: Fakhiramma B., Parvathi G, Parvathi P, Sanneappa T., Ramesh K. and Sharanappa G. in Koppal

With H. Somashekar in Bangalore

With Chandan Mukherjee in Trivandrum

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With Sundari Ravindran, Amar Jesani, U.S. Misra and fellow grantees in Mumbai

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Contents

Executive summary

The research discussed in the report revisits the notion of access to health care in Koppal, an economically disadvantaged district in northern Karnataka. This issue is important to households experiencing the effects of economic and health sector reform. It is now common knowledge that such reforms have benefited the rich and middle classes but not the poor. Routine household health surveys do help us understand how iniquitous access to health care can be, but offer limited opportunities for a gender analysis along the crosscutting axes of caste, class, age and life stage. Such an exercise is more complex, but necessary, as a nuanced understanding would be impossible without it.

In its conceptualisation of access to health care, the study draws upon the framework outlined by Meera Chatterjee, which speaks of access as requiring the negotiation of barriers beginning with the individual and progressively involving her/his family, and ultimately the state/market in health care. The study also seeks to bring in insights from the social relations framework.

The data for this study is drawn from a large household survey conducted by a research team, including the author of this report, at the Indian Institute of Management, Bangalore. The survey included a section on self-reported morbidity, treatment-seeking and expenditure. It was conducted in 56 villages in two *talukas* of Koppal district where an action research project focussing on gender and health equity is located. The households were selected through a stratified sampling method in which PHC affiliation, caste, and economic class status were key. Information about caste and class was obtained from the results of a household census conducted six months before the survey. A 12.5 per cent sample was selected in a circular systematic fashion, with equal probability, after a random start. Locally recruited and trained interviewers who worked in "man-woman" pairs conducted the interviews with household heads and other individuals in the household.

The findings contained in this report are descriptive; the intention is to merely sketch how inequities appear to work in a backward agrarian region that struggles to survive periodic drought. Caste, class, and gender are discussed in terms of their influence over treatment-seeking decisions for short-term and long-term sicknesses. Other axes discussed, but individually, are age, marital status, and membership status within kin groups.

The study shows that access to health care is an important issue in poor villages in a district like Koppal, where 82 per cent of the households had one or more sick persons requiring

treatment. Although households did try to keep pace with growing demand for health care, inequities along the crosscutting axes of caste, class, gender, age, and life stage resulted in treatment for some, but not for all. Middle caste and middle class households were particularly hard-pressed to meet all of the growing needs for health care.

Severity of sickness, identified by difficulty experienced in carrying out daily routines, interacted with structural inequalities manifest in sex, caste and class, age and life stage; and the two together influenced treatment-seeking decisions. These combined effects were strongest, for women and men, vis-à-vis sicknesses that extended for a long duration, i.e., an average of two years. They were less obvious in the case of short-term sicknesses that lasted for an average of eight days. Men enjoyed unconditionally good access to health care for short-term sicknesses, but conditional access for long-term sicknesses. In contrast, women had consistently lower levels of conditional access for any type of sickness.

Inequities were fluid and situation-specific, at times, even though they are defined within a set of more enduring parameters. They changed over a lifetime. They were also affected by life events like marriage. At any rate, the axes were clearly interlinked and their interrelationships gave rise to a number of scenarios. When the entitlements emanating from one reinforced the other, the net result was highly positive. When the (dis)entitlements deriving from one axis reinforced those prescribed by the others, the net result was highly negative. But when the entitlements emanating from one axis countered the (dis)entitlements emanating from other axes, there were mixed results. However, the axes also had fixed effects at times.

Through the analysis, we saw how class-based inequities were more sharply defined than caste-based inequities. This might suggest that access to health care is now a function of economic status, of purchasing power, of affordability. However, caste and class together formed a powerful framework defining very stark inequities within each caste, between men and women, and across castes. SC/ST women who lived in households that subsisted on casual wage labour were the worst off.

Finally, women and men experienced economic barriers differently. Apart from marginalized women like married daughters in their natal homes, and SC/ST women in casual wage earning households who encountered economic barriers, most other women suffered from lack of acknowledgement of their needs. These responses stem from the gender biased normative structures that govern households. Men, on the other hand, who benefited from these frameworks, were less controlled by the initial barriers. Their major impediment was economic, and the lack of resources to pay for health care in the poor agrarian region in which they found themselves, ultimately deterred treatment-seeking