

Gender, caste, class, and health care access

Experiences of rural households in Koppal district, Karnataka

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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

Chapter 1

Introduction

Introduction

One of the pivots around which gender, class, and caste-based relations are configured is access to, and control over, resources that then become the basis of power. Resources could be tangible, such as income and assets, as well as intangible. Feminist discourse has shown us how crucially the status of women in the household affects work burdens, health care needs, and access to a range of public and private resources, including health care. [1, 2]. Barriers to health care are manifestations of women's low status, lack of autonomy, and rights. We now know that married women in the reproductive age group, as well as older women, experience the greatest morbidity, but have the poorest access to health care. [2].

The research described in this report revisits the notion of access to health care, with a focus on gender and equity, in the age of health sector reform.¹ Health sector reform programmes are guided by notions of efficiency rather than equity, and focus on supply, rather than demand side issues. In such a context, access to health care is a double-edged sword. Not having it is disempowering and amounts to denial of one's rights, but the consequences of having accessed and paid substantial sums for care could also be detrimental to the economic and social well being of the household. Participatory poverty assessments by Krishna and others in diverse contexts in Rajasthan (2003), Gujarat (2003), Andhra Pradesh (2004), and in Kenya (2004) have shown that medical expenses are invariably among the three most important reasons why households fall into poverty. [3,4,5,6]. Such expenditures also exacerbate the vulnerability and deprivation of households that are already poor.

Public health specialists reviewing this phenomenon in a variety of health sector contexts

call it the "medical poverty trap." [7]. In post-reforms China, for instance, indebtedness was an outcome of catastrophic health emergencies. [8]. More recently, in 2003, an analysis of catastrophic health expenditures in 59 countries showed that these were highest in transitional economies and in a few Latin American countries. [9]. India was not among these 59 countries, so it would be difficult to assess its relative position at an international level. However, a recent World Bank document assessing the health sector in India estimated that direct out-of-pocket payments could push 2.2 per cent of all health care users, and a fourth of all hospitalised patients, into poverty in a year. [10].²

Contributing significantly to the rising costs of health care in India are the prices of drugs. This follows the gradual and incremental deregulation of drug production and pricing since the 1970s. [11,12].³ Newer, more potent, but also more expensive drugs have been aggressively introduced into the market by pharmaceutical companies through their representatives. As doctors tend to directly benefit from these marketing strategies, such drugs quickly find their way into the everyday world of medical practice. This has a direct impact upon the amount that patients have to spend on their treatment.

Other facets of reform that have impacted upon health care costs since the 1980s are growing state support for private health institutions through tax exemptions [14], and allotment of government land in prime urban locations [15]. This has happened amidst stagnating public finance for government health institutions [16] and cost recovery schemes in public hospitals [17,18]. The 1990s also saw the privatisation of public health institutions and the involvement of private providers in specific programmes offered by the public health

¹ The reform process has had an impact on financing strategies and the role of the state in the provisioning of health care.

² These estimates were based on unpublished National Sample Survey (NSS) data.

³ An analysis of drug prices between 1980 and 1995 revealed a 197 per cent increase overall for 778 selected drugs. The sharpest increases were evident in the prices of imported drugs, those that enjoyed a near monopoly, as well as those prescribed for chronic ailments. The prices of "inessential" drugs and irrational combinations also increased. [13].

system.⁴[19-23].

These reforms have resulted in growing inequities in access to health care along the crosscutting axes of gender and class. This is best illustrated through a comparative analysis of the 1986-87 and 1995-96 NSS surveys of health utilisation and expenditures. [24]:

- By the mid-1990s, the private sector had become dominant in the delivery of both outpatient and in-patient services and the average cost of all care (particularly of in-patient care) had gone up significantly. In relative terms, costs of hospitalisation had shot up in public hospitals, particularly in rural areas. These sharp increases in in-patient costs brought down utilisation rates in rural areas. The class gradients in fact showed that it was the rich — not the poor — who were now the major users of public hospitals. [24].

- Despite methodological problems with the NSS data, untreated morbidity among the poor was seen to have increased. Class-based inequalities in access to health services had clearly worsened for both men and women. However, the change in the class gradients for both untreated morbidity and hospital utilisation was somewhat sharper for men. This relative worsening of access for poor men, even though they continue in absolute terms to be better off than poor women, may imply that by the mid-1990s poor households were really stretched to breaking point in terms of access and affordability of health services. [24].

1.1 Situating the present research

The present research takes this inquiry forward in a deprived region of northern Karnataka where an action research project focusing on gender

and health equity is sited.⁵ The project aims to improve the health awareness of communities, their access to public health services, and the accountability of government health workers in 56 purposively selected villages.⁶

Koppal is one of the poorest districts in Karnataka where drought periodically takes its toll on the agrarian economy.⁷ Employment opportunities in the non-agricultural sector are few. Income security through agricultural self-employment is also limited to a few. And casual agricultural labourers earn wages that fall below the stipulated legal minimum. Women are worse off because their wages are even lower than that of men.⁸ This general lack of income security induces out-migration especially in the lean season, and drives poor families into work at great risk to their health and well-being. At the peak of the lean season, poor Dalit families, hard-pressed to meet basic needs, end up at the doorsteps of moneylenders or other informal lenders, and thereby begin — or continue — the cycle of debt and obligation.

Amidst these economic hardships are belief systems and traditional practices that are strongly gender-biased. Poor women's lives in such a situation are marked by low levels of literacy, poor diets amidst unrelenting labour, recurring fatigue, and illness amidst a denial of their rights. Their reproductive and sexual rights in particular leave a lot to be desired. It is no wonder then that maternal deaths happen far too regularly; that commonly experienced maternal and reproductive morbidities end up in the realm of silence; or that anaemia is endemic, but only casually and ineffectively addressed by public health programmes.

⁴ For instance, the Punjab Health Systems Corporation was set up by bringing 150 public hospitals under its purview. [19]. In some places, privatisation meant contracting the services of private bodies for non-medical essential services in government hospitals. [20,21]. In others, it led to contracting the services of private specialists and hospitals for first referral services. [22]. In other instances, retail outlets and private practitioners were enlisted to market contraceptives. Private practitioners were also oriented and trained for rational management of priority health problems and national programmes. [23]. Finally, the government also set up autonomous societies to facilitate easier disbursement of funds and to support the AIDS Control, Blindness Control and Reproductive and Child Health Programmes. [21].

⁵ The project comprises a tripartite partnership between the Indian Institute of Management, Bangalore, Mahila Samakhya, Karnataka, and the Department of Health and Family Welfare, Government of Karnataka.

⁶ The project combines community level action, joint planning between community representatives and government health departments, and collaborative research. The project's focus on actions aimed at enabling safe motherhood is the lens through which the issues of awareness, access and accountability will be addressed.

⁷ Only the areas in the vicinity of the Tungabhadra dam receive water for irrigation; the rest of the district depends largely on the erratic rains.

⁸ During the agricultural season, the daily wage is Rs. 15 for women and Rs. 20 for men. Out of season, the same work fetches only Rs. 12 for women and Rs. 15 for men.

In some ways, the demographic transition in Koppal has barely begun. With high birth and death rates and relatively low life expectancy,⁹ such an observation is fairly obvious. Part of the reason for high birth rates is the age structure itself. In our survey, we found that 50 per cent of the population was 18 years or younger. This age structure itself creates the momentum for population growth. Additionally, early marriages¹⁰ and son preference alongside infant deaths and a denial of reproductive rights result in women having to endure repeated pregnancies.

Health care in this context is poorly developed and unevenly distributed. As expected, larger and more accessible villages support more health care “options” in the public and private sectors than poor, remote villages. Unqualified medical practitioners (popularly called RMPs) are the dominant providers in a health sector that includes a large contingency of informal providers like traditional and spiritual healers, pharmacies, and provision stores. Formal providers do exist in the public and private sectors, but their numbers are smaller. Qualified private practitioners are mainly located in the *taluka* headquarters or in towns in the vicinity. Several of these practitioners own and run their own nursing homes with barely enough equipment to conduct uncomplicated surgical procedures. There are no private hospitals in the two *talukas* in which the study was located.

Government hospitals are better equipped than private nursing homes but constrained by the lack of specialists, and are incapable of dealing with emergencies. Many of the public health centres too are understaffed¹¹ and / or ill equipped. Much depends on who the doctor in-charge is: an enthusiastic and competent hospital manager can make a difference to even the most apathetic institution. Some public health providers with busy OPDs charge consultation fees just as private practitioners would. Drugs are inadequate and are

reportedly of poor quality. And there is not one blood bank to be found in the entire district. High-tech medicine does not really exist in the way that it does in metropolitan cities, and there is no supply-induced demand for it.¹²

A number of reasons contribute to this state of affairs. First, an inadequate state budget for health care that is partly misappropriated by elected representatives at the district level and the district health administration. Second, the overall underdevelopment of the region makes it difficult for the district to easily attract medical and paramedical professionals. Third, the lack of stable leadership at the level of the district health department makes it difficult to think of sustained reform. Fourth, the indicators used to measure worker and programme performance focus upon service outcomes that pay no attention to notions of quality, ease or speed of access, or worker responsiveness. In fact, government health services have tended to be so top-down in their approach, so gendered, so poor in quality, and so unresponsive that they have been unable to bridge the gap between service providers and their intended beneficiaries.

By locating our research in such an area, we are in a unique position to understand the nature of inequities vis-à-vis access to health care. How gender operates within caste-, class- and life stage-based relations is reflected in the way in which sicknesses are perceived and treated, in expenditures that are incurred and the burdens that are imposed upon family members.

Taking such a disaggregated view is not only more realistic and true to the situation on the ground, it also allows a more nuanced understanding to emerge. Health care utilisation studies consider social inequalities like class and sex-differences more broadly, but rarely explore the way in which gender and class relate to – and cross cut – each other. Qualitative studies, such as those by

⁹ People's lay perceptions reflect this: 30 years is considered to be the age at which people become tired beings; by the time they are 50, they are considered to be very old.

¹⁰ The average age at marriage for girls is around 12 to 14 years. For boys, it is 16 to 18 years.

¹¹ The district administration recently recruited a large number of doctors on “contract” and the health administration filled up several of the vacant posts of Auxiliary Nurse Midwives. However, the demand for these workers along with Male Health Workers and Lady Health Visitors far exceeds supply at this point.

¹² Supply-induced demand is limited to injections: patients demand them at the first opportunity and health providers are more than happy to oblige.

Sauerborn et al, Wilkes et al, Lucas and Nuwagaba [25,26,27], and reviews such as those by McIntyre and Thiede [28] focus on how households cope with catastrophic health expenditures. [25,26,27,28]. Not all of them are sufficiently gendered in their understanding, however. For example, we do not know for which member, and under what circumstances, expenditures are incurred with catastrophic consequences. Nor do we really know the implications of financing strategies for the status of autonomy of the sick person and others directly involved. The research proposed is timely and relevant for this reason, and it is hoped that it will ultimately deepen current understandings of the medical poverty trap from a gender perspective.

1.2 Conceptualising access to health care

Access to a resource refers to the opportunity available to use it. [29]. These opportunities are socially constructed and constrained by structural inequalities. Meera Chatterjee in 1988 posited five gateways or barriers that stand between women and their access to health care [30]:

1. Need for health care: as reflected in the existence of a health problem.
2. Perception of need: or whether the person with a need recognises and acknowledges it.
3. Permission: or the social factors that determine whether women can seek care beyond what is available in the household.
4. Ability: or the economic factors that determine the opportunity cost of health care outside the home.
5. Availability of health care services outside the house: including distance, timings, staffing, etc.

The family controls gateways two to four, through a set of gender-biased norms, values and practices, while the state and market control gateway five. Social institutions do this by creating and perpetuating unequal social and gender relations through:

- *Rules*, both official and unofficial, which determine what is done, how it is done, by whom it will be done, and who will benefit.

- *Activities*, which follow a routine pattern of practices that are determined by the rules, and

which result in unequal rewards that reinforce inequalities between men and women and between different age groups. Questions like who does what, who gets what, and who can claim what are important here.

- *People* who are to be allowed in, and who are excluded; who are assigned resources, tasks and responsibilities; and who is to be positioned where in the hierarchy. The selection of individuals reflects and reinforces class, caste, and gender inequalities.

- *Mobilisation and distribution of human, material and intangible resources*. The intangible resources are information, time, skills, membership of networks, self-confidence and credibility, political or social resources, rights and claims on people, experience of working in the public sphere, and leadership qualities. These resources become important in poverty contexts and often determine the capacity of individuals and households to respond to and cope with illnesses.

- *Power, or relations of authority and control* that result from unequal distribution of resources and responsibilities that official and unofficial rules serve to promote and legitimise. (March 1999, drawing from Kabeer 1994). [29].

The advantage of the social relations approach outlined above is that it allows us to consider how gender relations are configured and operate within class and caste relations. Bringing these two frameworks together, the dynamics of access to health care from a gender perspective could be summarised as follows:

- Access to health care is a mediated process involving the negotiation of a series of barriers at the individual, familial, and community levels. The ease with which individuals negotiate the gateways outlined in Chatterjee's framework depends on their social location within on-going gender and social relations.

- Recognition of the existence of a health problem is a subjective process open to biases and adverse norms. Notions of what is considered to be normal in a given context play a role here: The silences that engulf women's health problems are not because they do not exist. Women themselves may look upon them as normal bodily responses to the work they have to do. [31]. Moreover, when certain types of health conditions are widely

prevalent, women treat them as normal / natural states and ignore them. [32]. In Koppal, for example, chronic aches and pains are so widely prevalent that women see these as an inevitable aspect of their being, rather than as health conditions requiring some intervention.

Qualitative research suggests that women who recognise their health problem may ultimately choose to remain silent if they fear adverse reactions from the family or community. [33]. There are times when women and their family members will not publicly acknowledge their health problems. Adolescence is one such vulnerable period in Koppal because girls who are seen to be sickly have poorer chances of marriage. This is because not everybody has the privilege to deviate from what is considered to be normal and appropriate.

How do men perceive illness? It is believed that men are in a better position to talk about their illnesses: in fact, the national surveys which elicit morbidity information from the heads of household are better about capturing male morbidity. Even so, we know little about how willingly men reveal their reproductive health problems. During focus group discussions before the survey, men were clearly uncomfortable while questioned about even commonly experienced health problems. The older men who had waxed eloquently earlier about caste and class were completely ill at ease until the topic was changed. Do men equate illness with loss of strength, or masculinity?

- Acknowledgement of the need for treatment by self and by others is the next step after an illness has been recognised. Only then are social and financial considerations encountered. In other words, acknowledgement is necessary but not sufficient for access to health care. These barriers are not discrete entities. On the contrary, they influence and feed into each other. For example, notions of what the household can “afford” could influence the process of acknowledgement. Similarly, the permission to continue with treatment might cease when it is seen as being too expensive.

- Being a valued member of the family is likely to diminish the obstacles to treatment-seeking: Sicknesses are likely to be acknowledged and taken more seriously; treatment is likely to be more quickly

accessed; and social support for the sick person is likely to be more forthcoming. The nature of the sickness and the difficulty it causes in normal functioning is an additional consideration. The analytical question to be asked is: for whom, and under what circumstances is access to health care more forthcoming? This will be followed up in the discussion of study findings later in the report.

- Time is an important entitlement that enables access to health care. How much time do people have, away from their routine work, to visit a health provider? And for how long can they afford to rest when they are sick? The Dalit *sangha* women in Koppal who participated in focus group discussions prior to the survey mentioned that they did not have the luxury of being sick for too long as their husband accused them of being lazy, even if they found it impossible to carry out their usual chores. Time in this instance is closely tied up with freedom or privilege: the freedom to opt out for a period from the gendered division of labour within the home; the privilege of rest when sick.

- Critical to the question of access to health care is the one of access to resources, both tangible and intangible. Inevitably, the individuals with the greatest access also have a better say in decision-making. This is because the notion of agency itself is a product of better access to and control over resources within the household and beyond. Agency is also linked to fall back options that enable better bargaining power. The manner in which health care decisions are taken forms the basis for one set of inequities.

- Having the freedom to travel is also important if health care has to be accessed outside the house. But individuals enjoy different levels of mobility at different stages in their lives. For example, a pubescent adolescent does not have the same degree of mobility as an older woman, or a married woman with children. In the case of upper caste women, the fear of pollution due to inter-marriage or illegitimate sexual contact with lower caste men, who will not be admitted into their intimate circle, results in severe regulation and control over their sexuality and mobility. [1]. This control is particularly strong during childbearing ages. Restricted mobility directly affects their access to health care outside the household.

1.3 Scope of the research

The research presented in this report explores the structural basis of inequities in access to health care. It seeks to examine the ways in which class-, caste-, gender-, age- and life stage-based inequalities are reflected in the ability of individuals to get treatment. A specific question that emerges in light of the discussion on medical expenses is: to what extent do economic barriers limit access to health care for people divided on the basis of caste, class, gender, age and life stage?

The analysis stops short of examining the quantum and quality of health care accessed or the

types of health providers consulted. It also does not seek to understand the pattern of changes that characterise treatment-seeking. It merely looks at the structural factors influencing the ability to seek treatment and to continue doing so when necessary. We distinguish between those ever treated and never treated in the case of sicknesses lasting less than three months. We distinguish between those continuing with treatment, those discontinuing it despite feeling sick, and those never treated in the case of sicknesses lasting three or more months. Annexure 1 presents the organising framework for such an analysis.

Chapter 2

Methodology

The analysis of access to health care is derived from one part of a cross-sectional household survey conducted for the Gender and Health Equity Project in Koppal district. The survey was designed to document intra- and inter-household inequities in health care-seeking during sickness and pregnancy. It also sought to elicit household level attitudes to education of girls, health care during pregnancy, and domestic violence.

2.1 Sampling strategy

The project area consists of 56 villages affiliated to eight Primary Health Centres in Yelburga and Koppal *talukas*. A census conducted between December 2001 and January 2002, five months prior to the survey, enumerated 15,358 households within the project villages and a total of 82,901 individuals. Two characteristics of each household that were identified during the enumeration exercise were critical for the sampling design: religion-caste and average monthly per capita consumption expenditure.¹³

2.1.1 Sampling design, stratification, sample size and allocation of samples

A unistage-stratified sampling design was adopted with households as the sample units. The project villages under each PHC were grouped, and each group treated as a separate stratum. With eight PHCs in the project area, there were thus eight strata. A sample was drawn from each stratum to the extent of 12.5 per cent of all the households within it.

Two factors governed our decision about the sample size: the objective of the survey and a concern for feasibility. The objective of the survey was to conduct an equity analysis along the cross cutting axes of caste, class, and gender. This meant that our sample had to be large enough to allow us to do this. However, we also had to keep in mind the availability of educated people we could recruit and train, and the timeframe for the data collection. Taking these two factors into consideration, we decided to cover 12.5 per cent of all households (or one eighth), which worked out to 1920 households. Table 2.1 gives the total number of households and the number of sample households selected within each PHC stratum.

Table 2.1: Number of villages, households, and sample households in each stratum (PHC)

Serial no.	Name of PHC	Number of project villages	Number of households in the population	Number of households in the sample
	Koppal taluka			
1	Irkalgadda	7	2148	268
2	Kinhal	4	797	100
3	Ginigera	3	430	54
4	Kukanpalli	2	595	74
	Yelburga taluka			
5	Hirevankalkunta	20	4625	579
6	Sanganhal	7	3013	375
7	Mangalore	10	2869	360
8	Kuknoor	3	881	110
	All	56	15358	1920

¹³ Average monthly per capita consumption expenditure was used as a proxy for income in view of the well-known difficulties with estimating and measuring income in rural settings.

2.1.2 Selection of sample households

In order to obtain representative samples of households belonging to different religion-caste groups as well as economic classes, the following selection procedure was adopted. In each PHC, the households were first grouped into five religion-caste groups: the first four were Hindu caste groups¹⁴ and the fifth comprised mainly Muslims and a few Christians. Within each caste group, the households were arranged in ascending and descending order of MPCE¹⁵ and then each household was given a continuous serial number.

Using such a sampling frame, every eighth household was selected in a circular systematic fashion with a random start, until the required number of sample households within each stratum was reached.

The sampling strategy allowed for substitution of the selected households in the field, if they were not available despite repeated attempts to contact them, or if they refused to participate in the survey. This was carefully done; by selecting the household listed immediately after the one requiring substitution; in the same village, and within the same caste group.

Table 2.2 Interview schedule

Module	When canvassed	Theme	Respondent
Module 1	During every interview	Brief demographic and socio-economic profile of each member of the household	Head of household, their spouse or any knowledgeable adult
Module 2	During every interview	Socio-economic characteristics of the household	Head of household or their spouse
Module 3	During every interview. Two schedules per household	Gender-specific attitudes to education, marriage, pregnancy, domestic violence	Groups of household members – men and women separately
Module 4	If pregnancy was identified	Pregnancy outcomes, complications and medical attention during pregnancy, delivery and the post natal periods, expenditure and household burdens	Pregnant woman preferably, or her mother/mother-in-law or husband
Modules 5.1 or 5.2	If sickness was identified		
Module 5.1	If individual was sick for less than 3 months	<i>Short term sicknesses:</i> duration, difficult in carrying out daily routine, treatment sought expenditure and household burdens	Sick individual Preferably, proxy
Module 5.2	If individual was sick for 3 months or more	<i>Long term sicknesses:</i> duration, impact on life stage activities, treatment sought, expenditure and household burdens	Sick individual Preferably, proxy
Immunisation	If child under 3 years present	Whether immunised and types of health facilities used	Mother of child or any other knowledgeable adult

Note: The shaded sections indicate the modules that have been appended to this report.

¹⁴ The project field staff grouped individual castes according to the status awarded to them in the community.

¹⁵ In the first group, households were arranged in ascending order of MPCE; in the second group, they were arranged in descending order; in the third group, the order was changed once more.

2.2 The survey tool

A close-ended interview schedule was canvassed with household members. The schedule was broken down into six modules each focusing on a set of related issues. This made it a flexible tool that could be canvassed in any order, or simultaneously with different members of the household if need be. Table 2.2 outlines the intent of each module and with whom it was ideally canvassed. Relevant sections of the interview schedule are appended to the report (see Annexure 2).

In the survey, we made a distinction between sicknesses that are shorter from those that continue for long durations of time. This is because the duration of a sickness can have very different consequences for the sick individual and for her/his family. Three months was taken as a cut off time period and two modules were created in the interview schedule. The sicknesses that last for less than three months were termed so-called “short term sicknesses,” while those extending for three or more months were termed, for the sake of convenience, as “long term” sicknesses.

This was only a way to group sicknesses in order to make questioning more meaningful. Our terminology is not derived from in any biomedical notice of disease; rather it is a social construct that is intended to filter the experiences of sickness and the consequences that it could have on the sick individual himself/herself, caregivers and others in the household who are most affected by it. The survey did not adopt disease tracers, but tried to capture as full a range of short and long-term illnesses and injuries as possible through a probe list.

2.3 The survey team

The survey team comprised 27 members, apart from the team from IIMB (Aditi Iyer and Asha George), and two retired field supervisors from the National Sample Survey Organisation (NSSO). As the intention was always to have a woman-man pair conduct each interview, we had to recruit appropriate persons and match them on the basis of their relative strengths.

The women interviewers were the project staff, several of who were novices to community mobilisation or any field action.¹⁶ The more experienced fieldworkers were all matriculates between the ages of 31 and 37 years. The newer recruits were younger women, aged 19 to 32 years with better educational qualifications: five were educated up standard twelve, while four had BA degrees. Most of the community organisers were upper caste women (*lingayats*) and almost all were unmarried. Most of them were from Koppal district; only a few were from surrounding districts.

The male interviewers were as young as the new field staff with ages ranging from 19 to 34 years, but with slightly lower levels of education. Only one had a BSc degree while nine had PUC level education, and one did not study beyond SSLC. Four were currently studying; two worked and studied at the same time, while six had completed their studies and were on the lookout for employment opportunities. Almost all of the male interviewers belonged to the middle and lower castes. All of them had homes in the project villages.

Almost all of the interviewers had never participated in a survey before, let alone a health survey. Eleven to 12 pairs conducted the interviews on any given day. Three individuals were assigned the responsibility of handling survey forms and taking care of logistics.

2.4 The research process

2.4.1 Pre-data collection

The pre-fieldwork / data collection phase was characterised by intense discussion between members of the IIMB research team and its consultant. These discussions led to the design of the sample, and the interview schedule. Feeding into these discussions were reflections from a series of focus group discussions with *sangha* women and / or their husbands in six project villages. This exercise was a very useful one that helped us to understand how people perceived and experienced health needs and access to health care. It also helped us to understand how people defined social class and how they would group castes into smaller clusters.

Prior to data collection, Mahila Samakhya

¹⁶ There were 12 cluster co-ordinators and two *taluka* co-ordinators. Only five of them had worked in Mahila Samakhya before. The rest were recruited specially for the project.

held village-level meetings to inform village leaders and the village health volunteers attached to the project about the survey being proposed and to seek “community” consent for the research. They also recruited the male interviewers for the survey.

Training for the interviewers followed. As none of them had participated in a survey before, let alone a health survey, they had to be trained to conduct interviews, and exposed to health concepts and research ethics that were completely new to them. Intensive training was therefore organised for them on these issues. Ideally, this training should have extended for a fairly long period of time; however, it would have been difficult for this newly constituted field team to absorb abstract ideas for an extended duration. Mahila Samakhyas’ own approach to training has been to intersperse abstract learning with practical experience. We attempted to do the same.

- A first round of training was organised during which the team was introduced to the interview schedule and its key concepts, both medical and social. This was followed by practical sessions during which visiting *sangha* women sportingly put up with some rather inept questioning. At the end of five days of intense activity, a pilot was conducted in a non-project *sangha* village and *sangha* women and their families were interviewed. The lessons learnt from this first round of training were incorporated into another version of the interview schedule. The final version was translated twice, and preparations for a second round of training were made.

- The second round of training focused on the art of interviewing, the process of obtaining informed consent, other ethical norms to be followed, and revisited the newer version of the research tool. Certain sections of the schedule that were translated in Bangalore, were retranslated into the local dialect. A second pilot in another non-project *sangha* village followed. Debriefing after this second pilot helped to highlight critical issues that were systematically reviewed. Observations of the

strengths and weaknesses of each interview throughout the period of training, and pilot testing, helped the IIMB research team create the pairs who were assigned the responsibility of conducting the interviews.

An itinerary was developed with the help of the field researchers who knew more about the location and accessibility of villages, as well as market days, and festivals. Only then were we in any position to begin data collection.

2.4.2 Data collection

The interviews were conducted by 11 pairs of interviewers from July to September 2002. As the survey was taking place during the “peak” agricultural season, we knew that the interviews could only take place early in the morning or late in the evening, when people were not busy at work. We were clear that we were not going to disrupt people’s work schedule or take too much of their time.

All of the interviews took place in people’s homes.¹⁷ They began after informed consent was obtained through an informal process of rapport building,¹⁸ and the handing over of a letter explaining the survey and the larger project.

Information was gathered from adult members who could give credible information about themselves and others in the household, as indicated in Table 2.2. Children, mentally challenged /mentally ill or deaf individuals, were not questioned directly. The interviewers re-visited the household if key respondents were unavailable.

The sequence in which these modules were covered differed across households, as the interactions were varied and opportunities for privacy and small group discussion presented themselves differently. The interviewers conducted different sections of the interview simultaneously, after completing Module 1. This division of labour reduced the time required to complete the rather lengthy interview schedule to just half an hour on average.¹⁹ Moreover, it made it possible for the

¹⁷ On occasion, the researchers conducted an interview with a sick person away from the house, in order to establish a more private space for reflection and sharing, but these were rare occurrences.

¹⁸ Our partner in the field advised us not to ask for written consent, as there was a tendency for people to suspect the motives of those who did.

¹⁹ The time required for an interview depended upon the size of the household, and the number of sick or pregnant persons who lived there. If nobody was sick or pregnant, modules 4, 5.1 and 5.2 were not filled. The interviewers usually wrote down only the most essential information during the interview; they would complete their forms after the interview was over.

interviewers to handle the multiple interactions between household members during the interview as it helped them to engage everybody at the same time. This prevented bored members from walking away and, more importantly, created private time for one-to-one interaction in what are essentially non-private spaces. The strategies adopted by the interviewers to separate the men and women in the household prior to the more probing questions on pregnancy and illness helped to create as conducive an environment as possible for uninhibited discussion.

The research team sought to protect confidentiality of the responses received in each interview by making sure that interviewers did not conduct interviews in their own villages, and that the interviews were not discussed with curious community health workers who helped organise the survey team's visit in every village. Every form was checked for major errors, discussed with the interviewing pair and put away, out of reach.

2.4.3 *Post-data collection*

Data processing activities during this phase included:

- An elaborate scrutiny programme to streamline the use of codes, translate qualitative notes, list the responses grouped under the residual category “any other,” and systematise the detailed information that was gathered from a sub-sample for a few questions.
- Listing of each illness description mentioned in every interview schedule that could, at a later stage, be coded into symptom complexes.
- Design of the structure of the database, with unique codes to identify and link every member and household, and with built-in validity checks.
- Computerisation of the data using software specially created for the survey. The software was designed to minimise data entry errors with built-in validity checks.
- Quality checks of the data, including a 20 per cent random sample of the data that was inputted, and validity checks followed.

As the survey was expansive and quite detailed, and the sample size was large, the above

data processing activities were extremely time consuming.

2.5 *Dilemmas and challenges*

- The survey employed local interviewers as we strongly felt that our research should also build local capacity, and introduce all those involved to health issues through this process. This strategy worked in many ways. The ability to converse in the local dialect enabled better communication and made the interviews less obtrusive than they could have been. The involvement of local interviewers also enabled a more grounded understanding of morbidity reporting and treatment seeking.

However, we were never really in a position to choose the interviewers,²⁰ whose capacity and aptitude varied greatly. This is reflected in the somewhat uneven quality of information in the survey, particularly in the enumeration of sicknesses.²¹ Moreover, being products of the local ethos, they tended to go along with cultural notions of “normalcy” while recording illnesses. They did not always spell out the meaning of local (ill)-health terms, in terms of the symptoms associated with them and were, sometimes, too embarrassed to probe into the possibility of reproductive health problems. To tackle these issues, the research team had to continually support and supervise their work and then spend considerable amounts of time, energy, and resources on data validation. This uneasy relationship between capacity and the demand for rigour and quality characterised almost the entire process.

- The thin line of separation between the private and public spheres of social life in villages posed a constant challenge to the notions of privacy and confidentiality during the interviews and after. The interviewers and the research team responded to this problem by devising different strategies but this was not always easy.

- The interviewers tried to counter the tendency for key decision-makers and other powerful members within households to articulate their ailments more frequently than those without equal power, by repeated one-to-one questioning with different members. This was more easily done

²⁰ Given the low levels of literacy in the district, it was not easy to find educated persons who were in a position to get involved.

²¹ Such enumeration depends on the manner of questioning during the interview.

if most members were present during the interview, if there was enough space and privacy for one-to-one questioning, and if the interview had not already taken a lot of time. The trade-off between time and depth of information was not always easy to resolve.

2.6 Note on how morbidity was recorded

Sicknesses were enumerated through a series of questions:

- First, was there any sickness during the recall period (one month prior to the date of survey)? This information was obtained by asking questions at different points during the interview. A probe list was created that combined the questions used by the Madhiwalla et.al [2] and by Bhatia and Cleland [34] in their work in Karnataka. The interviewers were asked to go through the list but there was no uniformity in the manner in which they used it or the quality of their questions.²²

- Once a sickness was identified, it was categorised into a “short term” or “long term” sickness. As a thumb rule, all sicknesses that lasted for less than three months were termed “short” term sicknesses (and covered under Module 5.1). All those extending for 3 months or more were termed “long” term sicknesses (and covered under Module 5.2).

- Sicknesses lasting less than three months were further categorised into episodes. Bouts of the same sickness separated by a week were listed as separate episodes. If the gap between the bouts were less than seven days, they were counted as one.

- We had to use time as a critical marker of sickness, rather than bio-medical criteria. Though not ideal, this was necessary: such criteria would have been difficult for the investigators to cope with, as they were neither well educated, nor professional investigators. This was made more difficult by the manner in which sicknesses were perceived and experienced.

People had their own cultural explanations for illness and did not always articulate their health needs in ways that fit into our biomedical understanding of health and disease. For example, they tended to attribute some of their ailments to metaphysical causes, like *muttu dosha* or the

“polluting touch of a menstruating woman not belonging to the family” that causes illnesses among young children. They also attributed seemingly unrelated causes to their present health conditions. For example, women attributed lingering weakness, backache, and white discharge to their tubectomy weeks, months or, at times, years before. This perception has been captured by many studies, not ours alone. Is there a link between the quality of family planning services and lingering morbidity afterwards? Or were these poor women under some gross misconception?

In poor rural communities, people sometimes suffered from co-morbidity because of poor health overall, without their necessarily perceiving, or reporting it as being separate. In several instances, what got enumerated were sickness-complexes, rather than individual diseases.

- To get around these problems, we asked individuals about the difficulties they had in carrying out daily activities or social roles because of their sickness. These objective criteria specially focused on the *difficulties* people had, rather than the activities they actually managed to do despite the difficulty. The criteria were developed after conducting focus group interviews with Dalit *sangha* women in several of the villages covered by Mahila Samakhya. All individuals who had difficulty with one or more activity or social function were categorised as having a “severe” sickness.

For short-term ailments, the indicators used to define severity were:

- o Inability to eat normally.
- o Difficulty in doing regular work outside the home.
- o Difficulty in doing normal work inside the home.
- o Difficulty in going out of the house.

For long-term ailments, the indicators used to define severity were:

- o Difficulty in going to school.
- o Difficulty in doing housework.
- o Difficulty in doing other work like collecting fuel, fodder, water.
- o Difficulty in earning an income.

²² Some wove in the questions while conversing with household members, some pulled out the list at the beginning and asked the questions in a mechanical fashion, many of the male interviewers simply would not ask other men, especially those who were older than them, about possible reproductive health problems. They were too embarrassed to do so.

Chapter 3

Key equity stratifiers

3.1 Caste

The caste system is a variegated structure in which individual castes are endogamous and discrete groups. While recognising this important fact, we are still compelled to group these unique identities into three clusters in order to make data analysis possible. The following scheme represents a third attempt to group castes, and is by no means a foolproof method, as castes are sometimes difficult to categorise, and subjective judgements must be made while doing this.²³

- Upper castes: the traditionally “non-labouring” castes that did not engage in manual labour.
- Middle castes: the traditionally “labouring” castes that did engage in manual labour.
- Scheduled castes and scheduled tribes: the groups most discriminated against.

Annexure 3 lists the individual castes that were slotted into these groups. Upper castes accounted for 28.3 per cent, middle castes for 37.8 per cent and SCs / STs for 26.7 per cent of all surveyed households. Among the group currently titled “other Hindu castes” were Barkeras who contributed three per cent to the total. Muslims were a minority contributing a mere 4.1 per cent to the overall distribution. There were no Christians in the sample.

3.2 Class

Economic class is a multi-faceted system of stratification. While we cannot claim to do full justice to it within the scope of a quantitative health survey, we still have some information that can be used to describe what class might mean in Koppal.

- Ownership of assets: like land, pump sets, and house. We do not have information on other productive assets or consumption goods that

are used so often in the listing of assets.

- Income: we identified the major sources of household income (one year prior to the date of survey) rather than quantified the income itself. This is because income is difficult to measure in rural contexts. Instead, we asked for information on expenditures and were then in a position to calculate average monthly per capita consumption expenditure. We were guided by the NSS system while doing this.

While these indicators do capture different facets of class, we are also aware that the survey does not capture social assets, like social networks, and the support and strength that are derived from them. Nor are we in any position to understand the power wielded, and the control exerted, over the functioning of decentralised bodies, or the opportunities and resources accessed through them.

3.2.1 *Pattern of landholding and income*

As Koppal is a dry and drought prone region, agricultural productivity depends not merely on the amount of land owned but also on the possibility of ground water irrigation. Even large tracts of land can be economically unviable if they are not irrigated. Bore wells and pump sets are important assets for this reason. Without them, people have no insurance against drought.²⁴

In our survey, we found that most households owned some land,²⁵ but only a handful owned “pump sets.”²⁶ The households without land (15.9 per cent), or with un-irrigated land up to 2.5 acres (18.3 per cent) accounted for more than a third of all households. When the households owning 2.5 to 5 acres of un-irrigated land (17.6 per cent) are added to this group, the overall share of landless and small farm-owning households to the total was

²³ This would be a point to consider later on while analysing differences between caste and access to health care.

²⁴ However, even these cannot stave off the effect of extended drought, as we discovered while the survey was underway, and during the two years that followed. There was widespread despair and people were hugely disgruntled with the lack of drought relief schemes. Forced out-migration was the only way in which people could support themselves and their families who stayed behind.

²⁵ As many as 84.1 per cent of the households owned some land, while 15.9 per cent were landless.

²⁶ “Pump set” is a term that is used locally to describe the system put in place for ground water irrigation. We found that three out of four households (or 75.7 per cent) did not own a “pump set.”

as high as 51.8 per cent. In contrast, the households owning less than five acres of irrigated land accounted for a mere 9.8 per cent. Similarly, the households owning irrigated land measuring five to 10 acres (7 per cent) or more (7.2 per cent), together accounted for a mere 14.2 per cent.²⁷

The major source of income for most households was through self-employment (53.4 per cent), followed by casual wage labour (39.8 per cent). Regular wage employment was rare, as only 5.2 per cent of the households derived their income from it.

Families were able to subsist on agricultural self-employment only when their farms were large, or irrigated, or both. Almost all (or 91.1 per cent) of the big landowning families with irrigated land measuring five acres or more, earned incomes through self-employment. This proportion was lower, however, among the families that owned less than five acres of irrigated land (72.8 per cent) and among those who owned un-irrigated land measuring over five acres (70.1 per cent).

The families that owned un-irrigated landholdings measuring less than five acres were not as comfortably off: 57.9 per cent were dependent on casual wage labour; only 36.1 per cent managed on their earnings from self-employment. Casual wage labour was also the major source of income for 61.6 per cent of the landless households. Although 21.1 per cent of these families did earn from self-employment, such employment would be mostly skill-based work that small artisans engage in like the weaving of baskets/pots, making broomsticks/pots.

The proportion of families that enjoyed the assurance of regular wages/salaries was relatively higher among landless families (13.9 per cent) but never exceeded five per cent for all of the categories of landowning families.

3.2.2 Ownership and quality of house

Most families (78.3 per cent) owned the houses they inhabited. However, only 29.1 per cent of the owned houses were *pucca*²⁸ structures.

Around one fourth (or 22.7 per cent) were semi-*pucca* structures but an overwhelming 48.1 per cent were *kuccha* structures.

Only a very small proportion (5.8 per cent) lived in rented houses. Rented houses were relatively better in terms of quality. Undoubtedly, a third (32.5 per cent) of these were *kuccha* and 24.2 per cent semi-*pucca*, but 43.3 per cent were *pucca*. This figure was higher than that for owned structures.

The proportion of government-allotted houses was only 14.3 per cent, lower than the proportion of SCs/STs in the population, for whom such housing is primarily meant. Such housing was almost invariably *pucca* (84 per cent) although 11.3 per cent were *kuccha* and 4.6 per cent were semi-*pucca*.

When these two facets are combined, we find:

- More than half of the houses (i.e., 55.4 per cent) were owned semi-*pucca* / *kuccha* houses. Three fourths of these households had electricity, but almost all were without toilets, or piped water supply.
- Less than a fourth (i.e., 22.8 per cent) were owned *pucca* houses. Around 90 per cent of these had electricity, but most of them were without toilets or piped water supply.
- Twelve per cent were *pucca* government houses. Only 57 per cent of these had any electricity, none had toilets or piped water supply.
- The remaining 10-odd per cent were either rented semi-*pucca* / *kuccha* houses (3.3 per cent), rented *pucca* houses (2.5 per cent), semi-*pucca* / *kuccha* government housing (2.3 per cent) and other ownership options (1.6 per cent). Around 60 per cent of these had any electricity. A few of the rented houses had attached toilets, and a few had piped water supply.

These facets of social class will be used individually in the analysis that follows in the rest of the report. I will not attempt at this stage to create an index of social class that might only obfuscate emerging trends.

²⁷ The households owning larger tracts of land of five or more acres but without groundwater irrigation accounted for the remaining 23.9 per cent.

²⁸ Adopting the NSS definition, we defined:

Pucca house: as one that has a pucca roof, pucca walls and pucca or kuccha flooring.

Semi- pucca house: as one that has a pucca roof but kuccha wall; or a kuccha roof but pucca wall. The quality of the floor could either be kuccha or pucca.

Kuccha house: as one that has kuccha roof and kuccha walls. The quality of the floor is immaterial.

3.3 Class characteristics of caste groups

- Upper caste groups: Most lived in nuclear or extended nuclear families headed by men, just like the other caste groups. A majority lived in houses that they owned: a third (or 32.9 per cent) lived in *pucca* and half (or 49.1 per cent) lived in semi-*pucca* or *kuccha* structures. Land ownership was more the norm, as a relatively small group of households were landless (13.3 per cent). While 28.6 per cent owned less than five acres of un-irrigated land, 28.5 per cent owned irrigated land: 20.1 per cent owned more than five acres, and 8.4 per cent owned less than five acres. And an equivalent proportion owned more than five acres of un-irrigated land (28.9 per cent). The major source of household income for nearly two-thirds of all such households (or 64.6 per cent) was through self-employment. Although the group earning a regular wage was small in absolute terms (8.8 per cent), this proportion was still larger than that for other castes.

- Middle caste groups: Nearly two-thirds lived in semi-*pucca* or *kuccha* houses (62.2 per cent). Substantially fewer lived in *pucca* owned structures (21.7 per cent). Most households owned land, but these were mainly un-irrigated: 35.1 per cent owned less than five acres and 27.9 per cent owned more than five acres. The proportions owning irrigated land were slightly lower than those among upper castes: 15.6 per cent owned more than five acres while 9.8 per cent owned less than five acres. Income through self-employment did sustain most households, but this proportion was lower than that for upper caste households (58.8 per cent). On the other hand, there were substantially more households that subsisted on casual wages (36.9 per cent).

- Scheduled castes and scheduled tribes (SCs/STs): Nearly half of this group lived in owned semi-*pucca* or *kuccha* houses (53 per cent), which is a substantially smaller proportion than that for middle castes. On the other hand, 22.6 per cent lived in *pucca* government housing, which is higher

than that for upper and middle castes. SC/ST households were either landless (20.9 per cent) or owned less than five acres of un-irrigated land (45.8 per cent). A majority subsisted on casual wages (59.2 per cent); only 34.7 per cent earned incomes through self-employment.

- Muslims: The largest proportion (i.e., 48.8 per cent) lived in semi-*pucca* *kuccha* houses, while 24.8 per cent lived in *pucca* houses, and 20.6 per cent lived in *pucca* government housing. Muslim families were either landless (29.6 per cent) or owned less than five acres of un-irrigated land (31.2 per cent). Some 22.1 per cent did own irrigated land, but only 13.6 per cent were over five acres, 8.5 per cent measured less than five acres. Despite this, 49.1 per cent of the households in this group subsisted on self-employment and the remaining were dependent on casual wage labour (40 per cent) or regular wage employment (9.6 per cent).

3.4 Kinship groups

Kinship groups vary greatly from single member households to large joint families where married couples and their married children co-exist under one roof. By analysing the pattern of relationships within each family, we have been able to identify the following groups:²⁹

- o Joint family: Comprises of two or more married couples with or without their children. The married couples could belong to the same generation or could belong to different generations.

- o Nuclear family: Consists of a man, his wife and their unmarried children. Ever-married children are treated as members of a nuclear household if they live without their spouse and children. This happens when they are widowed or separated and without children; when married girls are too young to join their conjugal homes, or married sons have wives who are too young to join the conjugal home; when a married daughter comes to her parents' home during her pregnancy with or without her children.

²⁹ The survey worked with a definition of family as any group living under the same roof and sharing a common kitchen for six months prior to the date of the interview. Married daughters who were pregnant or had recently delivered, and their children, were treated as temporary members. Given the limitations of this definition, we do not have information about members who are considered to belong to the family but who were not present. Were there some members who worked as migrant labourers elsewhere but who periodically returned for short periods of time when they were without jobs (e.g., during the monsoons)? Did some members living elsewhere regularly send money to the household?

- o Single member household: Consists of a single member of either sex.

- o Segmented nuclear household: Consists of a man or his wife and their unmarried children. A widowed parent living with his / her widowed / separated / unmarried child(ren) would also, in this instance, constitute a segmented nuclear household.

- o Extended nuclear family: Consists of members of a nuclear family who live with one or more additional blood relatives. These could include, for example, a widowed parent, a widowed / separated child and his/her children, an unmarried sibling(s), nephew / niece, or any combination of the above.

- o Segmented joint family: Consists of a single head of household (either unmarried, separated, widowed) who lives with a married couple (either married child and his/her family or married sibling and his/her family) with or without other blood relatives or relatives by marriage without their spouses.

- o Single head of household with unmarried or single children or parents.

The most common kinship type in this area was the nuclear family (43.1 per cent), not joint families (22.5 per cent). Variants of the nuclear and joint families did exist. The extended nuclear family was an important kinship type from among this group, accounting for 16.8 per cent of all households. Fragmented family structures like the segmented nuclear and segmented joint families were fewer (6.3 per cent and 5.5 per cent respectively). Single members belonging to different generations (3.3 per cent) were clearly in the minority. Lastly, single member households did exist and this is interesting, even though they constituted only 2.7 per cent of all households. There were substantial differences in the distribution of kinship structures by religion/caste.

3.4.1 Characteristics of kinship groups

Joint families were the largest, with an average (median number) of 11 members, three adult women between whom housework could be shared, and two economic dependents.³⁰ Most

families lived in houses they owned (90 per cent) and tended to have more land in general than other kinship groups. The numbers owning five or more acres of irrigated land were substantially greater than other kinship groups (26.2 per cent as against 14.2 per cent overall). On the other hand, fewer families were landless (8.5 per cent), or with un-irrigated land measuring less than five acres (27.7 per cent). In general, land was the force that held joint families together, as we would expect. Most families lived on the earnings generated through self-employment (65.2 per cent). This proportion was higher than that for all other kinship structures.

Nuclear families were smaller than joint families with an average of six members, one adult woman and no economic dependents. Most families lived in houses they owned (71.9 per cent) while 16.3 per cent lived in *pucca* government houses. More than half of such families (or 56.1 per cent) were either landless or owned small tracts of un-irrigated land; a mere 12.2 per cent owned five or more acres of irrigated land. Nuclear families were divided between those who were self-employed (51.4 per cent) and those who subsisted on casual wages (41.8 per cent); only six per cent lived on regular wages.

Single member families lived in poorer housing than the other kinship groups: many more lived in *kuccha* houses (65.1 per cent as against 42 per cent overall), and substantially fewer numbers lived in owned houses (58 per cent as against 78.3 per cent overall). In fact, relatively more families lived in semi-*pucca* / *kuccha* government housing (5.9 per cent), in semi-*pucca* / *kuccha* rented structures (12.5 per cent) or entered into informal living arrangements (7.8 per cent), as for example, a rent-free room adjacent to the house owned by a relative. These poorer housing options together characterised 26.2 per cent of all such families. Such families were mainly landless (45.5 per cent) or owned small tracts of un-irrigated land (37.6 per cent). More than half of them were dependent on casual wages (51.7 per cent), while a fourth generated income through self-employment (24.9 per cent). A large chunk (19.5 per cent) earned from "other" sources.

³⁰ We identified economic dependents as those who are said to be "too young or too old to work."

Segmented nuclear families belonged to the group of smaller families with an average of four members, two adult women and no economic dependents. Such families lived mainly in houses they owned (72 per cent), but these tended to be semi-*pucca* or *kuccha* dwellings (62.5 per cent). Land clearly did not lie at the basis of segmented nuclear families as they were either landless (23.8 per cent) or had only small tracts of un-irrigated land (47 per cent). As many as 55.9 per cent subsisted on casual wages, 31.7 per cent depended on earnings from self-employment; only 8.8 per cent earned regular wages.

Extended nuclear families were larger than nuclear families, with an average of seven members, two adult women and one economic dependent. Most lived in houses they owned (84.6 per cent). Unlike nuclear families, extended nuclear families owned land; only 8.9 per cent were landless. Most of these lands, however, were un-irrigated; 37.7 per cent were less than five acres while 31.8 per cent were over five acres. Most families earned through self-employment (58.5 per cent) and little over a third (37.4 per cent) subsisted on casual wages. The proportion of households earning regular wages / salaries was tiny (2.9 per cent).

Segmented joint families also had seven members, two adult women, and two economic dependents, on average. Such households also lived mainly in owned houses (77.4 per cent). Compared to joint families, many more segmented joint families were landless (22.2 per cent as against 8.5 per cent). Moreover, only a fifth (20.1 per cent) owned irrigated land: 31.5 per cent owned less than five acres and 25.2 per cent owned more than five acres. Half of them sustained themselves on their earnings from self-employment and two fifths subsisted on casual wages.

Single members belonging to different generations living together typically had five members on average, including two adult women and one dependent. Such families were better represented among those living in owned semi-*pucca* or *kuccha* houses (60.9 per cent as against 55.4 per cent overall) and slightly under-represented among those living in *pucca* government houses (8.8 per cent as against 12 per cent). Most of such families were landless (19.4 per

cent) or small landowners without pump sets (43.6 per cent); 25.8 per cent owned five or more than five acres of land, but these were un-irrigated. They were almost equally divided between those who subsisted on casual wages (47.8 per cent) and those who were self employed (40.8 per cent). The proportion of those living on regular wages / salaries (8.2 per cent) was the highest in this category than other kinship groups.

3.4.2 Characteristics of women-headed and male-headed families

Men headed a majority of the kinship groups (i.e., 81.3 per cent). They headed almost all joint, nuclear, and extended nuclear families (89.9 per cent, 97 per cent and 93.3 per cent respectively). Women, on the other hand, headed almost all single member units, segmented nuclear and single members of different generations (82.3 per cent, 81.3 per cent and 83.2 per cent respectively). They headed nearly three fourths (or 73.2 per cent) of all segmented joint families.

There were no substantial differences in the sizes of male-headed and women-headed households by kinship type, nor were there substantial differences in the caste distribution between these groups. Women-headed households were, however, substantially worse-off economically as evidenced below:

- Around 65 per cent of them were either landless, or small landowners. The representation of male-headed households in the same categories did not exceed 50 per cent.
- More than half of them (53.7 per cent) were dependent on casual wages, while a third (35.1 per cent) were self-employed, and 7.4 per cent received a regular wage. In contrast, more than half of all male-headed households (57.6 per cent) were self-employed; only 36.6 per cent were casual wage earning households. A mere 4.7 per cent received regular wages.

Male heads were younger than women heads of household. The average age of male heads of household was 40 years and the inter-quartile range was only 15 years, which means that not a great deal of variation existed in the age distribution. On the other hand, the average age of women heads of household was 50 years and the inter quartile

range was 20 years suggesting a wider dispersion within the age distribution.

Most male heads of household were currently married (95.3 per cent), unlike women heads of household, 82.8 per cent of whom were single. Two thirds (69.2 per cent) of them were widows, 7.7 per cent separated/deserted, 5.3 per cent *devadasis*, and 0.6 per cent never married. Only 17.2 per cent were currently married.

Male heads were relatively better educated than women heads. Whereas most women heads were illiterate (87 per cent), only a little over half of the male heads were illiterate (52.4 per cent). Around a fourth (or 21.4 per cent) had some primary schooling, 13.5 per cent had some high school education and nine per cent were educated until standard ten or above.

A little more than half the male heads of household were self-employed (55.5 per cent) while a fourth (i.e. 28.5 per cent) were casual wage labourers and a small proportion of six per cent were regular wage earners. The remaining eight per cent were economic dependents (7.9 per cent were too old to work). In contrast, nearly half of all women heads were casual wage labourers (48 per cent). A much smaller proportion of 17.2 per cent were self-employed and 5.7 per cent were regular wage earners. The remaining 29 per cent were non-earners: 16.5 per cent were mainly engaged in housework while 11.7 per cent were too old to work.

Taken together, the evidence clearly indicates that women heads of household were more economically and socially disadvantaged than male heads of household.

Chapter 4

Nature of health care needs and access

4.1 Magnitude of health care needs

The survey results reveal a huge burden of morbidity when aggregated at the household level: an overwhelming 82 per cent of all households had one or more sick members during the recall period. Exactly half of them had one sick person, over a third (or 35.7 per cent) had two sick individuals, around 10 per cent had three sick persons, and the remaining households (3.9 per cent) had four or more sick members.³¹

The median number of sick persons per household increased from one, among upper caste households, to two for middle caste, SC/ST and Muslim households. It went up from one in regular wage earning households to two in households that subsisted on incomes from casual wage labour and self-employment. This indicates that the need for medical care was widely experienced. These needs were greater in middle and lower class / caste families.

The survey also shows that as the number of sick persons in the household increased, the necessity of having to deal with so-called “short” and “long” duration sicknesses, simultaneously, also increased. In households that had one sick person, the percentage of short and long-term sicknesses among all the sicknesses that were reported was nine per cent. This percentage went up to 51 per cent in households that had two sick persons, and furthermore to 53 per cent in households that had three sick persons. As long-term sicknesses are likely to impact upon households very differently from short-term sicknesses, the strategies required to tackle them are intrinsically different from those required to deal with short-term sicknesses.

Households did actually respond to the sicknesses articulated by its members. There is a direct and statistically significant relationship between the number of sicknesses in the household and the number of sicknesses treated by the

household. This was true for all castes and classes, whether defined by land or house ownership and income source, and for all kinship groups. However, not *all* of the sicknesses articulated by members of the household were treated, especially as the demand for health care grew.

- When there was one sickness in the household, the percentage of treatment-seeking was 80.7.
- When there were two sicknesses, in only 64.3 per cent of the households were both sicknesses treated.
- When there were three, this percentage reduced further to 52.6 per cent, and stayed more or less at that level (i.e., 52.2 per cent) when there were four or more sicknesses.

This shows that even though households did respond to the growing demand for health care, ultimately there was some system of prioritisation at work, which resulted in treatment for some, but not everyone. Attrition was greater at higher levels of demand. This is what one might expect in a poor context like Koppal. The equity questions here are: are these decisions made on the basis of assessed need? Who assesses whose need? Whose perspectives prevail? Whose voices are heard? Do the persons with the greatest need have the opportunity to seek treatment? What are the factors that mediate treatment-seeking? And in what types of households is this attrition greatest?

As shown in Figure 4.1, all the gradients were negative which means that all households suffered attrition at higher levels of demand for care. However, only the gradient for middle caste families (-12.693) was significantly different from zero, indicating that the number of sicknesses in the household was an important predictor of their treatment-seeking capacity. For upper caste, SC/ST and Muslim households, on the other hand, considerations other than the number of sicknesses in the household might have a role to play in treatment-seeking decisions.

³¹ The number of sick persons was not necessarily greater in larger households and vice versa. On average, the fractions of the number of sick persons to all household members actually increased from 1:5 when there was one sick person, to 1:3 when there were two sick persons, to 2:5 when there were three sick persons and finally to 1:2 when there were four or more sick persons.

Figure 4.1: Percentage distribution of households treating all sicknesses by number of sicknesses per household for each religious/caste group

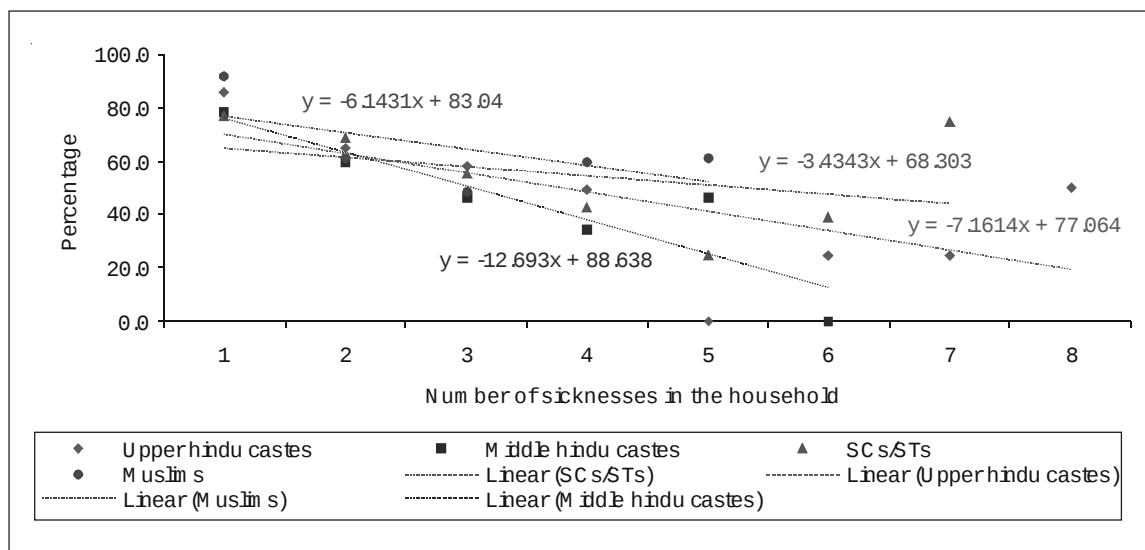
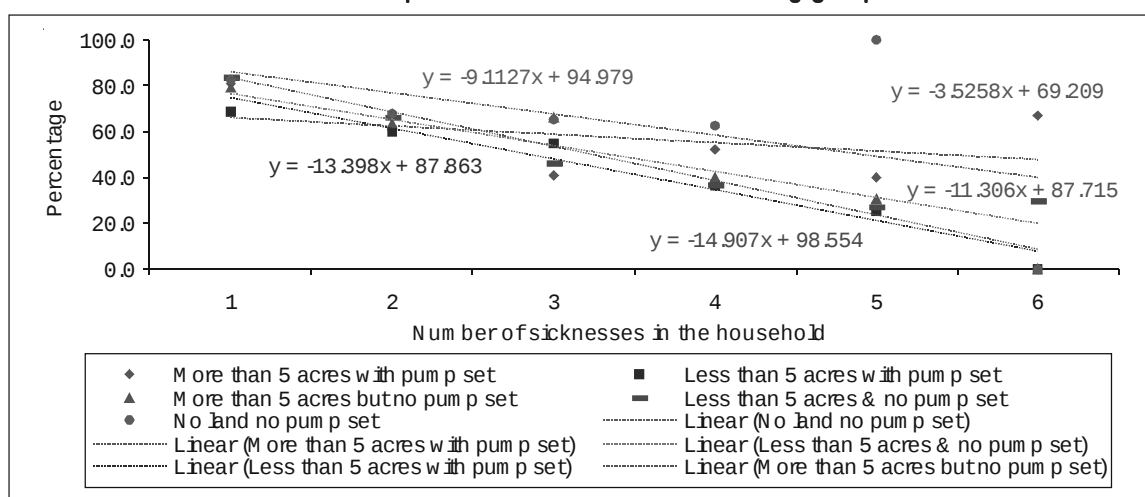


Figure 4.2: Percentage distribution of households treating all sicknesses by number of sicknesses per household for each landowning group



These negative gradients were also evident for households divided on the basis of economic class. The gradients for households that derived their income mainly from self-employment and casual wage work were negative, unlike the gradient for regular wage earning households; interesting, but not statistically significant.

However, the gradients *were* statistically significant for some categories of landowners, as shown in Figure 4.2. The number of sicknesses did matter to households that owned less than five acres of land, both irrigated (-13.398) and un-irrigated (-14.907), and to those who owned more

than five acres of un-irrigated land (-11.306). If we were to locate these households in a hierarchy, they would fall somewhere in the middle, and constitute the “middle class.”

The lower class, typified by landlessness, simply did not figure in this scenario. It is possible that treatment-seeking decisions for the poor are sensitive to influences other than the number of sicknesses in the household. This might well be the case for lower caste households as well. Similarly, the factors influencing upper caste and class households (typified by their ownership of large tracts of irrigated land) might also differ.

This diminishing trend was evident in all kinship groups, but significantly so in joint and nuclear families, which were the dominant kinship groups in Koppal. Headship, per se, did not seem to matter. Although the capacity of women-headed households to respond to the demand for health care was consistently lower than that of male-headed households,³² the gradients were almost identical, and statistically insignificant.

The findings presented so far show that while households in Koppal did respond in general to growing demands for health care, not all sick members managed to seek treatment. Middle caste and class households in particular were unable to provide care for all its sick members at higher levels of demand. This is because every sick person and every sickness is likely to have imposed additional burdens upon the household and its non-sick members. In response, households seem to have adopted some system of prioritisation of health care needs; and an analysis of the system at work is important from an equity point of view. Were the sicknesses that were perceived to be more “severe” treated first? Or did the social location of the individual prevail over all other considerations? Or did a combination of these inform the decision about seeking treatment? We will explore some of these dynamics in the next sections.

4.2 Duration and “severity” of short-term and long-term sicknesses

The average (median) duration for which people suffered from short-term sicknesses was eight days. There were no differences between men and women by caste and class (measured in terms of the major source of household income). On the other hand, the duration of the long-term sicknesses was as long as two years. Again, there were no differences between men and women.

Among those who suffered from short-term sicknesses, 45.6 per cent were unable to eat normally, 50.7 per cent were unable to do regular work outside the house, 45.2 per cent were unable to do regular work inside the house and 45.4 per

cent were unable to go outside the house.³³ The median number of difficulties per person was one for both girls/women and boys/men. In fact, an overwhelming 64.1 per cent found it difficult to carry out one or more activity.³⁴ In other words, the short-term sicknesses that were articulated tended to be mostly those that caused difficulty in daily functioning. In the analysis that follows, we divide individuals into two groups: those that experienced one or more difficulty, and those that did not do so.

Among those who suffered from long-term sicknesses, on the other hand, many more had difficulties in carrying out social functions: 41.7 per cent of those being educated had difficulties going to school, 55 per cent had difficulties doing housework, 60.3 per cent had difficulties doing other work, and 54.1 per cent had difficulties earning an income. Apart from the fact that more boys experienced difficulty in attending school than girls, there were no substantial sex-wise differences within all of these categories. The median number of difficulties per person was one for the boys/men, and two for the girls/women. As in the case of short-term sicknesses, a majority of long-term sicknesses (or 59 per cent) also caused difficulty in social functioning.

4.3 Overall pattern of access to health care

4.3.1 To treat or not to treat, or to drop out

The survey reveals very high levels of treatment-seeking: close to 90 per cent of the sicknesses reported by girls/women and over 90 per cent of those reported by boys/men were ever treated. This finding contradicts all that we know about health and treatment-seeking in poor contexts. The proportion of never treated episodes of short-term sicknesses among girls/women was no more than 11 per cent and that for boys/men was even smaller (3.9 per cent). Similarly, the proportion of never treated long-term sicknesses among girls/women was also 11.9 per cent while that for boys/men was 5.7 per cent. These

³² This is not surprising, given their relatively greater economic deprivation.

³³ The denominators for all of these calculations exclude the “not applicable” group.

³⁴ 15.4 per cent had difficulty doing one activity, 10 per cent had difficulty doing two activities, and 14.4 per cent had difficulty carrying out three activities, while a fairly large proportion of 24.3% had difficulty with four activities.

proportions are lower than those reported by many other utilisation studies in India.³⁵

A number of reasons that go back to people's perceptions of sickness and their experience of treatment-seeking may be at work here:

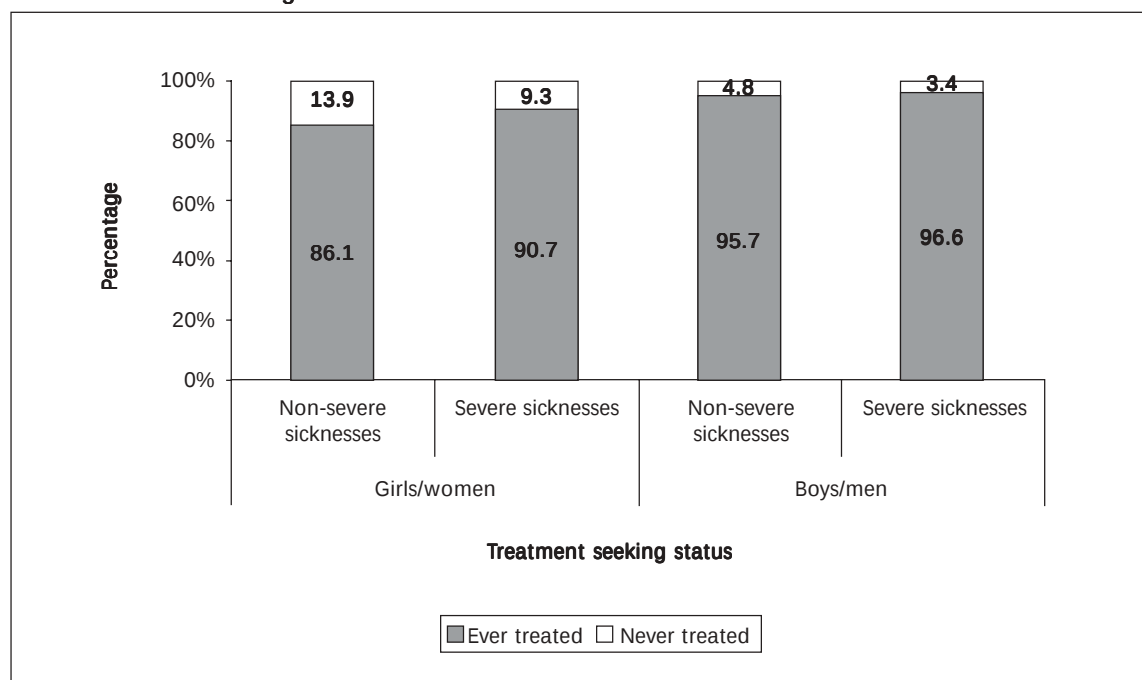
- **Quality of enumeration of sicknesses:** People tended to correlate sickness with treatment and report only those sicknesses that were treated. This observation has also been made in other studies [2] that were better about tackling this perception through the method of probing. We also used a probe list similar to the Madhiwalla study; however, our interviewers did not systematically probe for the sicknesses that are seen as being normal, despite their not being so. While the women interviewers were relatively better at recording reproductive health problems, even their knowledge was not wide enough at that point in time for a more systematic and considered approach to morbidity recording. The men were too young, and often too embarrassed, to probe

for reproductive health problems among men. Therefore, the low level of untreated morbidity is, in some ways, only indicative of the much larger burden that individuals might bear in silence.

- **Notion of treatment:** People do go out and seek some "treatment," but these do not necessarily entail sustained contact with a health provider or adherence to a course of treatment. Even those who are currently being treated may only be committed to sporadic visits to a health provider for one-time treatments (burning or branding of nerve endings, or injections). Moreover, as the survey takes a generous view of the notion of treatment³⁶ — it includes any action taken by self or by others around them to alleviate sickness symptoms — it has captured a seemingly high level of treatment-seeking.

- **The phenomenon of discontinued treatment despite being sick:** When the phenomenon of discontinued treatment is factored in, a different story begins to emerge. A substantial proportion of the long-term sicknesses were treated

Figure 4.3: Access to health care for short-term sicknesses



³⁵ These proportions are similar to those reported by the All-India survey conducted by NCAER in the early 1990s [35]. They are lower than that reported by NSS in the mid-1990s [36], but the NSS had a more restricted definition of treatment. They are substantially lower than the survey conducted by Madhiwalla et al in the late 1990s [2] in the poorer areas of one district in Maharashtra.

³⁶ We felt that it would make intuitive sense to do this in a poor context such as Koppal, given what we know about what treatment means, and how it takes place.

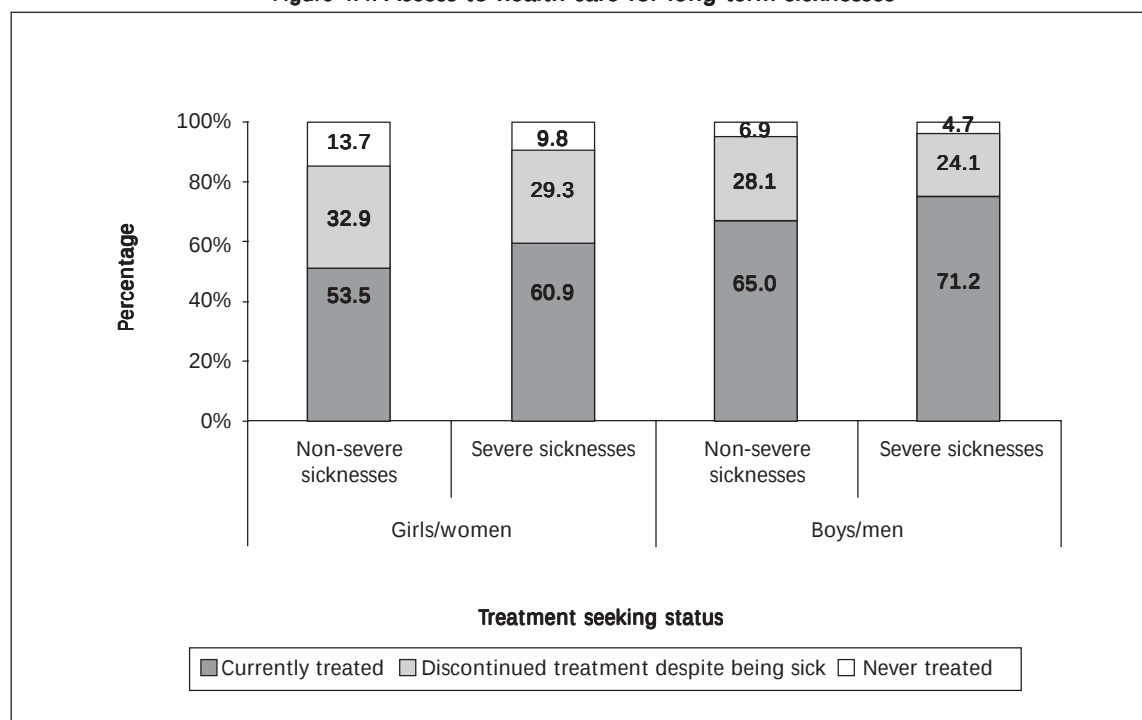
earlier, but even such treatment was discontinued despite the sick person continuing to feel sick. Treatment for 30.5 per cent of the sicknesses among girls/women and that for 25.9 per cent of those reported by boys/men³⁷ were discontinued. As a result, the proportion of sicknesses that were treated until the date of the survey (termed “currently being treated”) was substantially lower: only 57.6 per cent of the long-term sicknesses among women, and 68.5 per cent of those reported by boys/men were currently being treated. The phenomenon of discontinued treatment despite being sick is an important aspect of treatment-seeking that is seldom taken into account in utilisation studies.

There is some association between severity and access to health care for both short and long term sicknesses. The proportion of short-term, non-severe sicknesses that were ever treated by girls/women was 86.1 per cent, as shown in Figure 4.3. However, when the sickness caused difficulty in day-to-day functioning the proportion

of those ever treated was 5.3 per cent higher (at 90.7 per cent). This difference, though not substantial, was higher than that for men. Among the sicknesses reported by men, 95.2 per cent of the non-severe sicknesses were ever treated, as were 96.6 per cent of the severe sicknesses; the difference was a mere 1.5 per cent. This suggests that men had uniformly high levels of access to treatment regardless of the severity of their sickness. Women, on the other hand, had more conditional access that seemed to hinge upon whether or not their sickness caused difficulty in daily functioning. And even then, their access to treatment was lower than men.

A somewhat different dynamic is at play in the case of long-term sicknesses, as shown in Figure 4.4. Overall, women had lower access to health care than men, as evidenced by consistently lower levels of continuing treatment. Even though the proportion of their sicknesses receiving continuing treatment did increase by 13.8 per cent³⁸ when they were severe enough to cause difficulties

Figure 4.4: Access to health care for long-term sicknesses



³⁷ The total excludes the people who discontinued treatment because they were no longer sick. In this case, the “cure” would have taken place within the recall period.

³⁸ The increase was from 53.5 per cent for non-“severe” sicknesses to 60.9 per cent for “severe” sicknesses. Similarly, the proportion of discontinued treatment decreased by 10.9 per cent when the sickness was severe (from 32.9 per cent to 29.3 per cent).

in daily functioning, the maximum level attained (60.9 per cent) was still lower than the minimum level for men (65 per cent). Yet, access appears to have been conditional even for men. With relatively lower levels of access to treatment than was the case for short-term sicknesses, sickness-severity brought about greater treatment-seeking. The proportion of sicknesses receiving continuing treatment increased from 65 per cent to 71.2 per cent, an increase of 9.5 per cent. Discontinued treatment also decreased by 14.2 per cent.

4.3.2 *Reasons why people never seek treatment or drop out*

Decision-making is a complex process involving multiple actors with different levels of agency and preoccupations. While it was not possible to capture the many dimensions of decision-making, and all of the considerations weighing the decisions that were made, we did record the major reason why treatment was either

discontinued or never sought.

The reasons cited in the discussion that follows, point to the presence of barriers at different levels. Responses like “I did not know what to do” or “I did not think the illness was serious / I did not think it (i.e. treatment) was necessary” indicate the presence of barriers within the sick individual herself/himself. Responses like “Family did not think it was necessary”, “No one to accompany me” or “I did not have the time” reflect the presence of barriers in the family. On the other hand, responses like “Health provider was unavailable / unhelpful” point to limitations in the delivery of health care outside the home.

These barriers do not exist as discrete entities; rather they are influenced by each other. For example, the response “Treatment too expensive” reflects barriers at three levels:

- The increased cost of health care outside the home;
- An absolute lack of resources within the

Table 4.1: Percentage distribution of the major reasons why short-term and long-term sicknesses were not treated

Main reason for no treatment	Short-term sicknesses		Long-term sicknesses			
	Never treated		Discontinued treatment		Never treated	
	Girls/women Wt N=856	Boys/men Wt N=240	Girls/women Wt N=1944	Boys/men Wt N=1083	Girls/women Wt N=760	Boys/men Wt N=237
I didn't know what to do	6.4	0.0	1.5	0.7	9.6	3.4
I didn't think it was serious	39.1	23.3	11.1	12.6	42.6	29.1
Family did not think it was serious	11.9	10.0	1.2	2.2	12.5	6.8
No one to accompany me	2.8	3.3	0.7	0.0	3.2	3.4
I didn't have the time	2.8	10.0	1.6	0.0	0.9	3.4
Too expensive	23.1	46.7	20.0	21.6	17.6	40.5
Health provider unavailable	1.9	3.3	1.6	3.7	0.0	3.4
Health provider unhelpful	0.0	0.0	1.2	0.0	0.0	3.4
Medicines make me ill	0.9	0.0	0.0	0.0	1.1	0.0
Not getting cured	3.6	0.0	43.4	30.0	5.1	6.8
Other	7.4	3.3	4.7	5.8	7.4	0.0
No response	0.0	0.0	13.0	23.4	0.0	0.0
<i>Total</i>	100.0	100.0	100.0	100.0	100.0	100.0

household, including the inability to borrow or raise money through other sources;

- The sick individual's relatively poor access to intra-household resources to pay for medical treatment.

4.3.3 Main reasons why short term sicknesses were never treated

As shown in Table 4.1 most of the episodes suffered by girls/women were never treated because they mainly believed that their sickness was not serious enough (39.1 per cent). Another 11.9 per cent were never treated because their family did not think their sickness was serious. Together, half of the number of episodes suffered by girls / women (51 per cent) were never treated because of this seeming lack of seriousness. And yet, 54.6 per cent of the episodes that women thought were not serious actually made daily routines difficult. This means that the problem was not one of lack of seriousness per se, but one of self-censorship, lack of acknowledgement by self and by the family.

This belief did not dominate the worldview of boys / men to the same extent. A substantially smaller proportion of the episodes reported by them (33 per cent) were never treated due to this lack of seriousness / acknowledgement. In fact, self-censorship was substantially lower: only 23.3 per cent of the episodes reported by them were never treated because they believed the sickness was not serious (as against 39.1 per cent by women). And this might well have been the case because 71.4 per cent of the episodes in this group did not cause difficulty in daily functioning. At the same time, the lack of acknowledgement by the family resulted in almost the same proportion of episodes remaining untreated (10 per cent as against 11.9 per cent for women).

Unlike women, economic barriers were more sharply defined for boys/men. The major reason why nearly half of their episodes were never treated (46.7 per cent) was because treatment was too expensive. Substantially fewer episodes reported by girls/women were deterred for this reason (23.1 per cent).

This does not however mean that economic barriers are unimportant for women. Rather, what we are witnessing is women's

relatively slower or poorer negotiation of the barriers to access within the household. While most of them remained at gateway two (termed "perception of need"), men in fact went on to gateway four more easily (termed "ability"). This is where they encountered financial barriers that ultimately deterred treatment-seeking.

4.3.4 Understanding the dynamics of acknowledgement

Does acknowledgement have to be negotiated through discussion? Most of the individuals suffering from a short-term sickness talked about it to another person (90.9 per cent). The small group that did not discuss their sickness mainly believed that it was not serious. There were no substantial differences between men and women here.

However, when we look at the relationship between discussing a sickness and doing something about it, an interesting dynamic emerges. Almost all of those who did something about their sickness had also discussed it. However, this pattern does not hold true among those who did not receive treatment for their sickness: around a third of these individuals had also never discussed their sickness with anybody. Could this silence contribute to the problem of acknowledgement?

For example, around 60 per cent of the women who did not talk about their sickness because they thought it was not a serious matter, did not seek treatment for it. Similarly, around 67 per cent of those who remained silent because their family was not supportive also remained untreated. And around 75 per cent of the women, who were too shy or scared to discuss their sickness, were not in any position to obtain treatment for it.

In contrast, treatment for men was less affected by their being able to discuss their sickness. The reasons cited for women – i.e., uncooperative family, being too shy or scared – did not feature among the reasons given by men for their silence. And only a fourth of the men who remained silent because they believed their sickness was not serious were not treated for it. These patterns, though based on very small numbers, are very interesting. Being able to talk about an illness is the first step that women seem to have to take in order to acknowledge the need for care and negotiate

acknowledgement with other members in the household. It is a necessary but not sufficient condition to their being able to receive care.

4.3.5 Main reasons why long term sicknesses were never treated

This dynamic of lack of acknowledgement for women and economic barriers for men is evident in the reasons given for never treated long-term sicknesses. Most girls/women (i.e., 42.6 per cent) believed that treatment was unnecessary despite the fact that over two fifths of their sicknesses caused difficulty in daily functioning for as long as one year on average. Another 12.5 per cent were constrained because their family believed that they did not require treatment, and this despite over half of the sicknesses causing difficulty in daily functioning for close to three years on average. Clearly, treatment was not “unnecessary;” rather, a combination of self-censorship and lack of social/financial support³⁹ for treatment contributed to 55.1 per cent of the reasons why women's long-term sicknesses were never treated. Nearly a tenth (or 9.6 per cent) reported that they did not know what to do, but their response could well have been an expression of helplessness. Although 17.6 per cent did report that treatment was “too expensive,” the lack of acknowledgement seemed to be an overriding barrier for women.

Men, in contrast, were not held back to the same degree by such censorship. Instead, they were confronted more directly with economic barriers: 40.5 per cent reported that treatment was “too expensive.” Only under a third (or 29.1 per cent) believed that treatment was unnecessary, and this could indeed have been the case, as 76.8 per cent of the sicknesses did not cause difficulty in daily functioning through the two years of its existence. The problem of acknowledgement and social/financial support could have been at work in 6.8 per cent of the instances where the family

did not think treatment was necessary, as all of the sicknesses were severe enough to cause difficulty in daily functioning for more than six years. But this is a substantially smaller proportion of the reasons for no treatment.

4.3.6 Main reasons why treatment for long term sicknesses were discontinued

The major reason why both women and men discontinued treatment was because they did not feel better despite the treatment. More women than men (43.4 per cent versus 30 per cent respectively⁴⁰) reported that they were “not getting cured or that their sickness was incurable.” What were they saying really: Were they expressing their dissatisfaction with ineffectual treatment? Or did they believe that paying any more for ineffectual treatment was simply too outrageous to justify?

It would appear that in fact both these considerations might have prevailed for women and men. Both men and women were burdened with prolonged sicknesses – men for three years on average, women for two years – and, expectedly, men received treatment for a relatively longer duration than women.⁴¹ Despite this, they either experienced only temporary relief, or actually felt worse.⁴² The average expenditure incurred on the treatment of men during the last year out of three (Rs. 800) was also substantially higher than that incurred on women (Rs. 600)⁴³ and the burden on their family relatively greater as well. Although taking loans was comparatively higher among women than men (23.3 per cent as against 18.6 per cent), the average amount borrowed for men was substantially higher (Rs. 3000 as against Rs. 1000).

These findings actually indicate that both women and men were expressing their disillusionment with medical care *and* an inability to pay any more for such ineffectual care. The only difference is that while women discontinued

³⁹ There was a lack of social support within the home when nobody could or would do the work that the sick person customarily did. The response could also reflect the absence of financial security when the family is not in a position to absorb loss of wages or income.

⁴⁰ Taking away all “no responses”, these percentages went up to 49.9 per cent for women and 39.2 per cent for men.

⁴¹ Fewer women were treated for more than a year than men (27.8 per cent as against 46 per cent). On the other hand, substantially more women were treated for four to 12 months than men (around 20 per cent as against 7 per cent).

⁴² Many more men reported such poor outcomes than women (92 per cent as against 80 per cent).

⁴³ These expenditures were lower than for those women and men who found treatment was too expensive, and the women who did not have the time to seek treatment, but they were substantially higher than those reported by people in all the other categories.

treatment relatively quickly, men did so only after having spent considerably larger sums of money that had implications not only for themselves, but for others in the household.

Economic barriers were more clearly articulated by the people reporting one fifth of the sicknesses for which treatment was discontinued: 20 per cent of the women and 21.6 per cent of the men reported that treatment was, in fact, too expensive.⁴⁴ After suffering for three years on average, and taking treatment for considerably shorter durations of time, expenditure on treatment-seeking had resulted in loans for 24 per cent of the sicknesses reported by women and 27.5 per cent of those reported by men. To make matters worse, over 90 per cent of the women and men felt no better after treatment.

The third major reason why one tenth of the women and men discontinued treatment (women: 11.1 per cent, men: 12.6 per cent)⁴⁵ was because they believed that treatment was “unnecessary”. Further analysis shows that women’s sicknesses had, in fact, extended for a

year on average and caused difficulty with at least one aspect of daily functioning. Yet, treatment had made no difference to 78 per cent of them or in fact, made them feel worse. So, even while they might have said that treatment was unnecessary, they could also have been reporting the futility of treatment-seeking.

The discussion above shows how important it is to look at the complex of circumstances that inform what people say, while trying to understand the reasons for their health-seeking actions. It would seem that sick persons and their families weighed the effectiveness of treatment against the attendant expenditures. If treatment did not result in favourable health outcomes, then the individuals, who were unable to bear continuing expenditures, simply stopped all treatment. In this respect, women and men gave similar-sounding reasons for discontinued treatment; yet, the circumstances under which they made these statements were not quite the same. This lent an entirely new set of meanings to these common utterances.

⁴⁴ After taking away the no responses, women: 22.9 per cent, men: 28.2 per cent.

⁴⁵ After taking away the no responses, the proportion for women was 12.8 per cent and 16.4 per cent for men.

Chapter 5

Structural inequities in access to health care: Intra-household differences

It is now widely recognised that households are not homogenous units in which opportunities are equally shared. Rather, they are sites where entitlements are bargained for and negotiated between individuals with differing levels of power and agency.

5.1 Inequalities by membership of kin groups

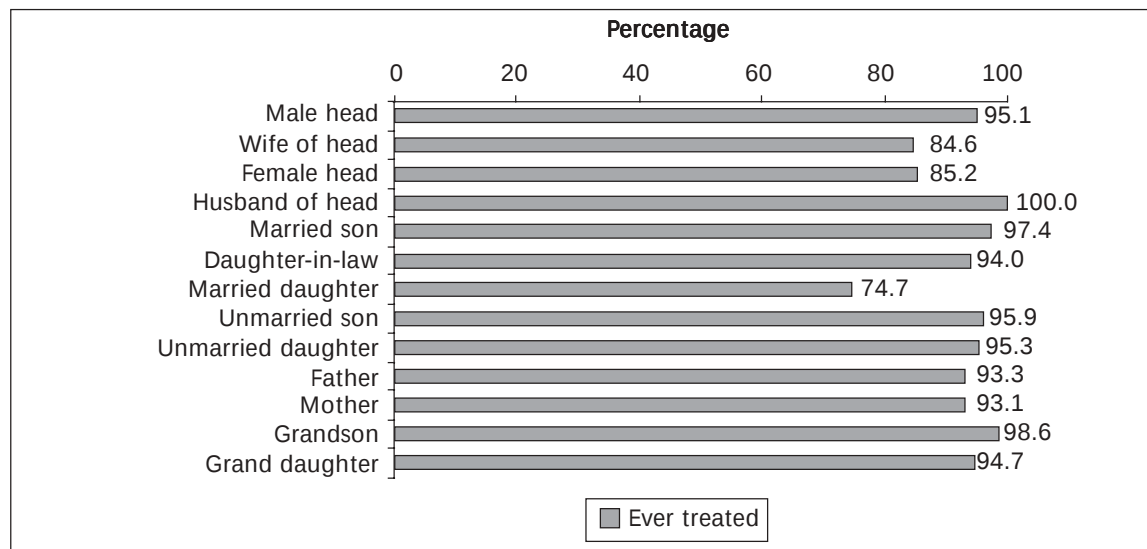
Membership status⁴⁶ is an important marker of inequity combining gender, age, and life stage entitlements. Male heads of household are in the best position to access resources and to make larger decisions regarding the use of money or the accessing of credit. In contrast, a young daughter-in-law in a joint family would not have the same voice in decision-making beyond herself, or her children. A pubescent daughter would not have the same mobility as an unmarried son of the same age. The wife / mother in a male-headed nuclear family would not have the luxury of time to seek treatment, or to rest, if there is no one who can – or will –

substitute for her labour. However, she might have the power to make decisions about seeking care if it does not involve major expenditure. Elderly parents may not be in a position to make decisions if they are no longer responsible for running the household; however, in deference to their age and relationship with the household head, their access to health care is not likely to be hampered. Some of these dynamics are illustrated in the patterns of access to health care for short and long-term sicknesses.

5.1.1 Short-term sicknesses: Differences by membership status

As shown in Figure 5.1 and in Table 5.1, male heads of household enjoyed very high levels of access to health care for short-term sicknesses: the percentage of ever treated sickness episodes among them was as high as 95.1 per cent. This was similar to that of (their) unmarried children (95 per cent), married sons (97.4 per cent) and parents (93 per cent).⁴⁷ In contrast, the wives of male heads had substantially poorer access: the percentage of ever

Figure 5.1: Members of kin groups ever-treated for short-term sickness



⁴⁶ Members are described in terms of their relationship to the head of household.

⁴⁷ The analysis does not capture differences within each household, and then aggregate these differences across households. Instead we have compared selected pairs of members across all households. They may not actually be related to each other.

treated sickness episodes among them was only 84.6 per cent. The situation did not reverse, however, when the head of household was a woman. The husbands of women heads clearly enjoyed better access than the wives of male-heads: the percentage of ever-treated sicknesses among women heads was the same as that for the wives of male heads (85.2 per cent), but (their) husbands were *all* treated, without exception. This is an illustration of how gender bias operated, even when the main decision-maker (i.e., the household head) was a woman.

These differentials changed when the sickness was severe enough to cause difficulties in daily functioning, but inequities continued to exist. For example, the differential between male heads and (their) wives reduced substantially due to more treatment-seeking by the wives. Even so, 12 per cent of the severe sicknesses among them remained untreated. The same can be said of the differential between women heads and (their) husbands.

In Koppal, marriage changes the claims that girls and boys have over household resources. Girls,

Table 5.1: Differences in access to health care by membership status

Relationships to head of household	Short-term sicknesses			Long-term sicknesses			
	Weighted N	% ever treated	% never treated	Weighted N	% currently treated	% disc. treatment	% never treated
Male head of household	2307	95.1	4.9	2332	70.4	22.6	7.1
Wife of male head	2898	84.6	15.4	3026	52.3	35.6	12.1
Female head of household	966	85.2	14.8	744	65.5	17.5	17.1
Husband of female head	55	100.0	0.0	121	73.6	26.4	0.0
Married son	302	97.4	2.6	319	77.4	15.0	7.5
Daughter-in-law	400	94.0	6.0	305	39.3	50.2	10.5
Married daughter	249	74.7	25.3	233	48.5	45.1	6.4
Son-in-law	32	100.0	0.0	32	50.0	50.0	0.0
Unmarried son	2562	95.9	4.1	896	54.9	41.6	3.5
Unmarried daughter	1840	95.3	4.7	687	65.2	19.7	15.1
Father	119	93.3	6.7	175	81.7	13.7	4.6
Mother	694	93.1	6.9	863	67.4	23.3	9.3
Father-in-law	8	100.0	0.0	8	100.0	0.0	0.0
Mother-in-law	55	72.7	27.3	38	42.1	57.9	0.0
Brother	159	100.0	0.0	96	75.0	25.0	0.0
Sister	81	100.0	0.0	217	70.0	19.4	10.6
Brother-in-law	9	100.0	0.0	16	100.0	0.0	0.0
Sister-in-law	82	100.0	0.0	113	50.4	35.4	14.2
Nephew	46	100.0	0.0	24	33.3	66.7	0.0
Niece	40	100.0	0.0	16	100.0	0.0	0.0
Grandson	590	98.6	1.4	152	84.2	10.5	5.3
Grand daughter	432	94.7	5.3	104	76.9	23.1	0.0
Other relationship	52	84.6	15.4	46	50.0	50.0	0.0
Total	13978			10563			

Note: Percentages are over the total number of sicknesses within each membership category

once married, are regarded as members of a different family, who cannot presume social and financial support from their natal home.⁴⁸ Married sons, on the other hand, are seen as contributing members. This is starkly evident in the treatment-seeking outcomes of married sons and daughters.⁴⁹ While almost all married sons (97.4 per cent) received treatment, only three out of four (or 75 per cent) of the sickness episodes reported by married daughters were ever treated. They were constrained mainly by lack of acknowledgement by self and by family members,⁵⁰ while (their) married brothers were not.

What is worse, this inequality actually increased when both suffered from severe sickness(es). Many more married sons were at liberty to seek treatment; married daughters simply did not do so. As a result, 25 per cent of their sicknesses continued to remain untreated. Moreover, their substantially poorer access compared to unmarried daughters (a gap of nearly 30 per cent) reduced only

slightly when both suffered from severe sicknesses. This shows how poor a young married girl's access to treatment is while she lives in her natal home, as she is clearly seen as a non-contributing visitor.

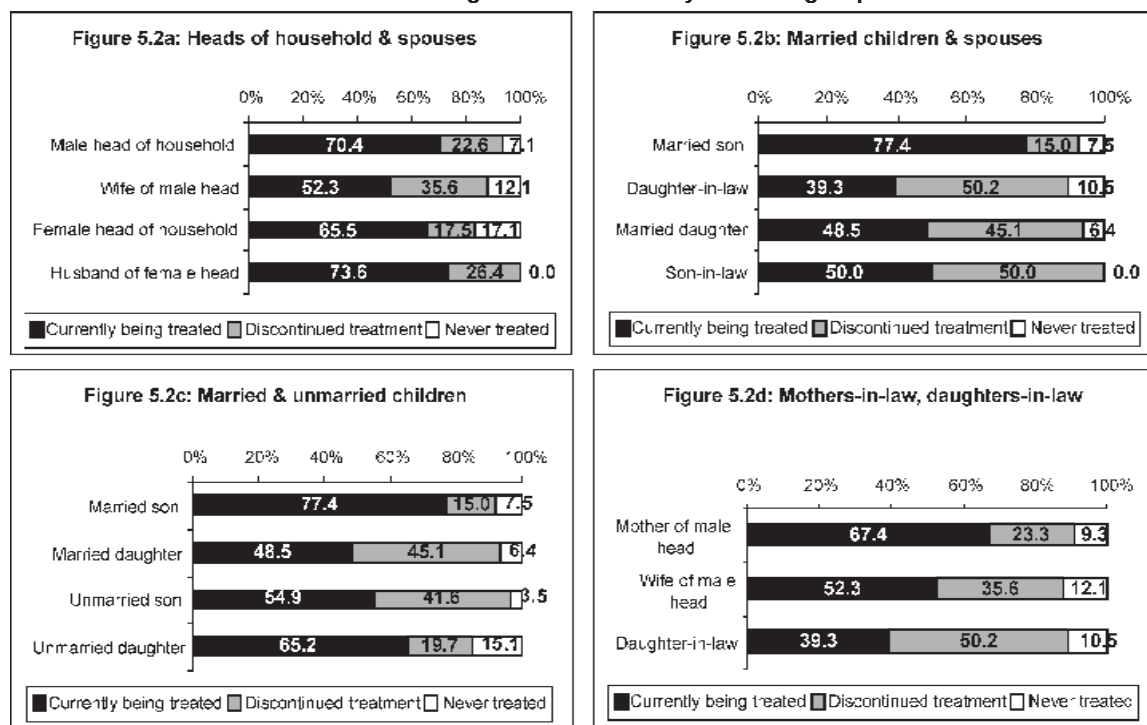
In contrast, as spouses and daughters-in-law in conjugal homes, married girls/women had much better access to treatment for short-term sicknesses, even better than (their) mothers-in-law. This could possibly be linked to efforts to restore their health so that they can continue to perform productive and reproductive functions, which are important for family maintenance.

5.1.2 Long-term sicknesses: Differences by membership status

Gender, age and life-stage based inequities were starkly defined in the case of long-term sicknesses, as depicted in Table 5.1.

As shown in Figure 5.2a, male heads of household had much better access than the wives of male heads: 70.4 per cent of their sicknesses were

Access to health care for long-term sicknesses by selected groups of members



⁴⁸ Even though parents do spend quite large sums of money on public ceremonies like the wedding itself, followed by the ceremony to commemorate a first pregnancy, and the child's naming ceremony, they spend substantially smaller sums on treatment-seeking during pregnancy and sickness for their married daughters.

⁴⁹ Many of these married daughters were in their natal homes because they were pregnant.

⁵⁰ Half of the never treated episodes were due to self-censorship and another 12.5 per cent were due to lack of acknowledgement by family members.

currently being treated as against only 52.3 per cent of the wives. The wives had either never been treated (12.1 per cent, 5 per cent higher than that for male heads), or had discontinued treatment despite being sick (35.6 per cent, 13 per cent higher than that for male heads). Such differences were substantially higher in joint families than in nuclear or extended nuclear families.

Interestingly, the women heading households had relatively better access than the wives of male heads: 65.5 per cent of their sicknesses were currently being treated as against 52.3 per cent, highlighted earlier. However, with 17.1 per cent of their sicknesses never treated and another 17.5 per cent resulting in discontinued treatment, they clearly did not enjoy the same access as the husbands. All husbands were ever treated; and even though 26.4 per cent of their sickness were no longer treated, the proportion of those currently being treated was still 12.4 per cent higher (73.6 per cent as against 65.5 per cent for the women). Such differences were greater in nuclear families than in joint families.

These differences reduced when all of these concerned individuals suffered from severe sicknesses. The women, in this instance, managed to catch up to some extent. Even so, a substantial proportion of their sicknesses were never treated: 11.2 per cent among the wives and 9.7 per cent among the women heads.

Married sons had relatively better access to care than even male heads of household (Figure 5.2b): 77.4 per cent of their sicknesses were currently being treated. In contrast, the access that daughters-in-law had was starkly lower. Only 39.3 per cent were currently being treated (38.1 per cent lower). While half of their sicknesses (50.2 per cent) were no longer treated, mainly because they did not feel better, or due to self-censorship, 10.5 per cent were never treated mainly due to lack of acknowledgement by family members and by self. These inequities were more sharply defined in joint families.

Marriage clearly did not work in the same way for sons and daughters as shown in Figure 5.2c. Married sons were empowered by it, unlike married daughters. Compared to married sons, unmarried sons had poorer access as 41.6 per cent of their

sicknesses were no longer being treated, and 3.5 per cent were never treated. The main reason why treatment was discontinued was because it was expensive and ineffective. In contrast, unmarried daughters had relatively better access than married daughters: 65.2 per cent of their sicknesses were currently being treated, unlike married daughters; most of whose sicknesses were either no longer treated (45.1 per cent) or never treated (6.4 per cent). Economic barriers mainly deterred them, due, no doubt, to their poor bargaining power.

Married daughters did manage to “catch up” with married sons when both had severe sicknesses, however. This is an important departure from their relatively unchanged position while suffering from short-term sicknesses. Some 52.4 per cent of their long-term sicknesses were “currently” being treated, whereas earlier only 37.5 per cent were ever treated at one time or another. Even so, 4.7 per cent of their sicknesses were never treated and as many as 42.9 per cent no longer treated, despite their being sick. This only reinforces our argument that contrary to common belief, married daughters received little support in their natal homes.

And yet, as daughters-in-law too, their terms of access were inimical, even when they suffered from severe long-term sicknesses. The differential between them and married sons increased substantially when both had severe sicknesses due to their dropping out of treatment-seeking. Between daughters-in-law and wives of male heads too, an interesting dynamic was at work. Whereas comparatively more daughters-in-law were receiving treatment for non-severe sicknesses than the wives of household heads (their presumed “mothers-in-law”), fewer were being treated when these sicknesses were severe. A large proportion of them simply discontinued treatment. As a result, the differential that had initially favoured daughters-in-law, strongly favoured the wives of household heads (mothers-in-law).

This adverse situation changed when the “daughters-in-law” were also the spouses of household heads. While they fared poorly compared to the mothers of the household heads when both had non-severe sicknesses, their relative situation improved when both had severe sicknesses. More

wives of male heads were able to secure treatment, while “their elderly mothers-in-law” stayed more or less at the same level as they were before. Even so, 11.2 per cent of their sicknesses were never treated.

This seems to suggest that inequities are fluid and open to negotiation, even though they are defined and contained within a set of parameters that are more enduring. For example, the inequities between parents and children were negligible when both grew older. There was almost no difference between male heads and mothers, while fathers actually had substantially better access than either (Table 5.1). This illustrates how changes in age and life stage-based status result in newer definitions of the terms on which individuals access treatment.

5.2 Gender and age-based inequalities

In Koppal, as in all rural areas, age is more generally equated with roles and responsibilities and different life stages. For example, biological events in a girl's life – puberty, pregnancy, and possibly menopause – are milestones ushering in newer responsibilities. These in turn signify time and years.

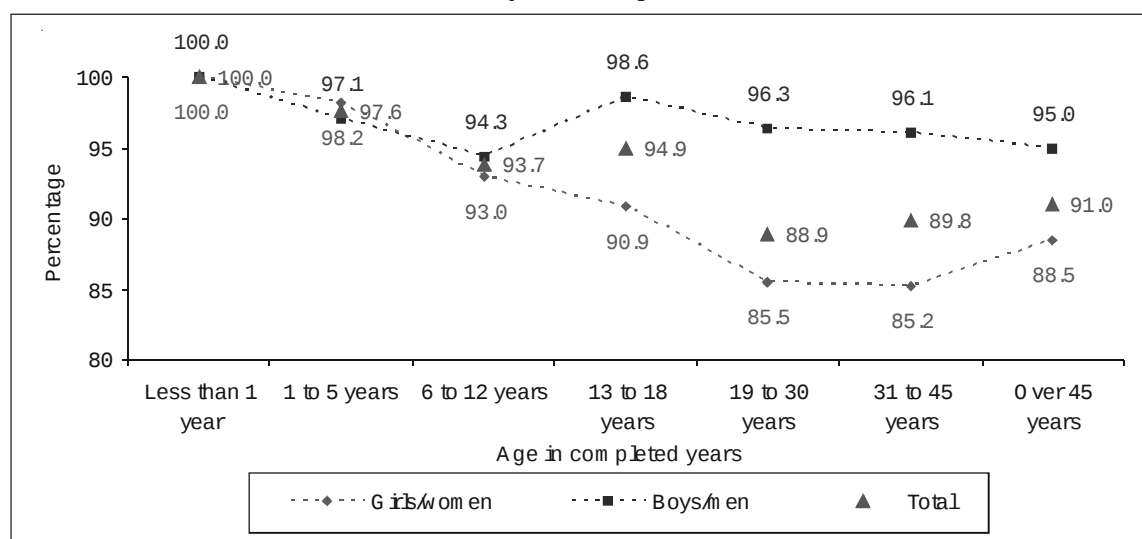
5.2.1 Short-term sicknesses: Gender differences by age

As shown in Figure 5.3 and Table 1 (Annexure 4), access to health care progressively declined over a lifetime for both men and women. The declines for women were greater after puberty

right until the end of their reproductive years. However, there was some improvement in their access to care during old age as depicted by a 22.2 per cent decline in the proportions of never treated sicknesses among them. Men did experience declining access to health care too but the declines were more gradual among them than women, and their access to care uniformly better at every interval. As a result of this, age and sex based inequities increased steadily, and to the disadvantage of women.

In fact, the differentials were particularly adverse for women between the ages of 19 and 45 years. Women were held back from seeking treatment during this stage by self-censorship and a lack of acknowledgement of their needs by their family. Severity of sickness did not contribute much to treatment-seeking during this period either. Only the smallest increases were in evidence for girls aged 13-18 and 19-30 years who suffered from severe sicknesses. On the other hand, a substantially higher proportion of treatment-seeking took place among boys/men of the same age who suffered from severe sicknesses. As a result, the sex differential that already favoured boys/men actually increased substantially, and 10 to 12 per cent of the severe sicknesses reported by girls/women remained untreated. Between the ages of 31 and 45, women suffering from severe sicknesses were probably taken more seriously, because treatment-

Figure 5.3: Short-term sicknesses: Percentage distribution of individuals ever treated by sex and age intervals



seeking increased substantially among them. Even so, around 10 per cent of their sicknesses were left untreated.

5.2.2 Long-term sicknesses: Gender differences by age

Access to health care declined for both women and men over a lifetime. However, the progression was not smooth. There were periods of sharp declines, plateaus and recoveries as shown in Figures 5.4 (a-c). Moreover, the sequence differed between the sexes in interesting ways.

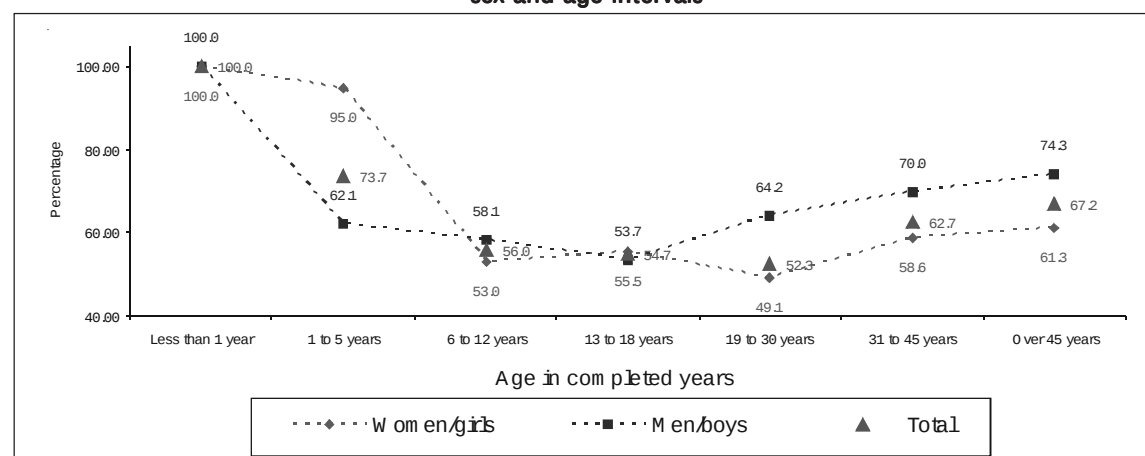
Girls enjoyed the greatest access to health care during infancy and early childhood, followed by substantially lower access during late childhood⁵¹ and their teens⁵² that only got worse during the early reproductive age group (19-30 years).⁵³ This trend of decreasing access to health care for

women, amidst growing work burdens, is a function of the way in which gender-biased norms and practices devalue their needs and rights within households. As women grow older, their ability to exert power over other women and children in the house increases. This is perhaps why their access to health care during subsequent years got better.

Infant boys also had the greatest access to health care, but there was a steep decline during early childhood,⁵⁴ which continued, but in less dramatic fashion, right until the end of their teens.⁵⁵ Afterwards, men enjoyed much better access until old age.⁵⁶ Due to these contrasting trends, the sex differentials favoured girls until their teens and men during the reproductive and older age groups.

Severity of sickness had the effect of altering inequities, which continued to exist in one form or another: During early childhood (i.e., ages

Figure 5.4a: Long-term sicknesses: Percentage distribution of individuals currently being treated by sex and age intervals



⁵¹ Even as girls begin to take on a growing set of responsibilities in and around the house during this period, they enjoy much reduced access to care. The proportion of currently treated sicknesses reduced by 44.2 per cent because of very high levels of discontinued or never treated sicknesses. While expensive but ineffective treatment brought about discontinuance, economic barriers and lack of acknowledgement resulted in never treated sicknesses.

⁵² This is a vulnerable period, as puberty spells impending marriage for girls. This is when girls are pulled out of school, when restricted mobility and greater work burdens begin to change their worlds. Married women in this age group also have the additional burden of early pregnancies.

⁵³ Women's lives in this period are characterised by their location in conjugal households, unrelenting work, repeated pregnancies and childbearing, and relatively poor contact with their natal homes, as is the cultural practice. Their relationships to the heads of household during this period were mainly as daughters-in-law or spouses of household heads, unlike men, who began to head households. Virtually none of the sick women of this age period were heads of household. The percentage of never treated sicknesses was highest during this period: 16.3 per cent.

⁵⁴ Continued treatment was substantially lower: 62 per cent versus 95 per cent among girls, 34.6 per cent lower, due to a very high level of discontinued treatment (35 per cent). Ineffective but expensive treatment was cited as the major reason for this discontinuance.

⁵⁵ Every boy received at least some treatment for their sicknesses but 46.3 per cent discontinued treatment due to treatment being expensive but ineffective.

⁵⁶ During old age, the access that women attained between the ages of 31-45 years continued at almost the same level, while men enjoy comparatively greater access.

Figure 5.4b: Long-term sicknesses: Percentage distribution of individuals discontinuing treatment by sex and age intervals

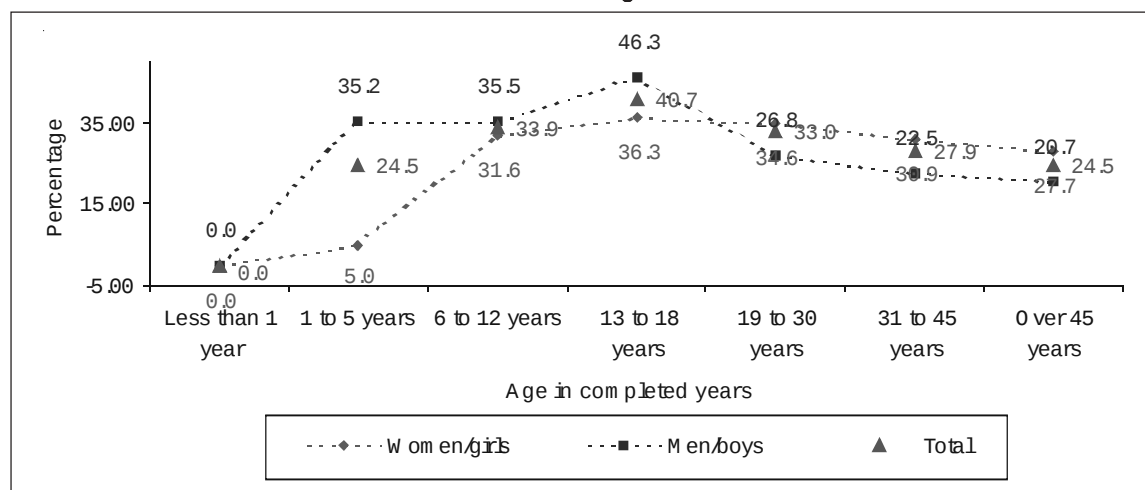
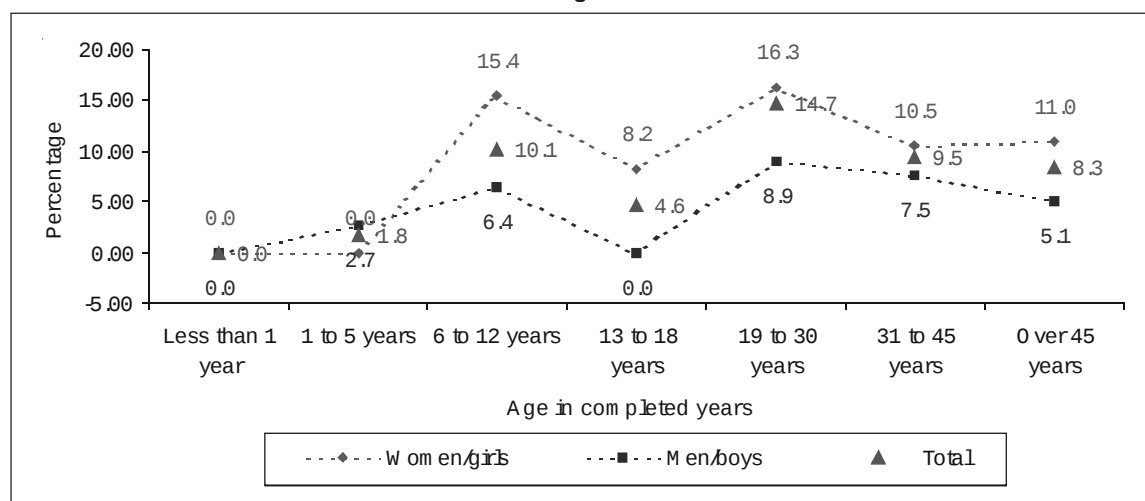


Figure 5.4c: Long-term sicknesses: Percentage distribution of individuals never treated by sex and age intervals



of 1-5 years), the sex differential that already favoured girls, when they suffered from non-severe sicknesses, only got heightened when both had severe sicknesses. All boys were ever treated, but due to higher proportions of discontinued treatment than girls, the proportion being treated was substantially lower.

During late childhood (i.e., ages 6-12 years), interesting inequities were at work. The sex differential favoured boys when both suffered from non-severe sicknesses, with 17 per cent of the sicknesses among girls never treated. When both suffered from severe sicknesses, treatment-seeking increased among girls but reduced among boys, so that they were both left with similar proportions

of never treated sicknesses (14 per cent among girls and 13 per cent among boys). However, as the proportion of discontinued treatment was higher among boys than girls (36 per cent as against 29 per cent), the sex differential ended up favouring girls.

Such a swing was also evident between the ages of 13 and 18 years. In comparative terms, boys had a slight advantage when they suffered from non-severe sicknesses. But when they both suffered from severe sicknesses, all boys continued to be ever treated as before, but some cases of discontinued treatment resulted in a drop in the proportion currently being treated. Treatment-seeking for girls, on the other hand, improved

substantially, so much so that many more were currently being treated than boys. The sex differential that worked adversely against girls, now worked adversely against boys.

This evidence of greater support for girls than boys during the early years may well be true in Koppal, although it is still an unusual situation. We should not discount the role of bias in morbidity reporting. As most of the reporting of morbidity and treatment-seeking was through proxy respondents for this age group (certainly until the age of 10 to 12 years), there could have been a tendency for parents to report only those instances where treatment took place, while ignoring the children whose sicknesses were not taken seriously. Birth order could also have played a role in terms of reporting of higher order births, but we are in no position to factor this into the analysis.

During the reproductive age group, however, there was a consolidation of male advantage which did not change even when both men and women suffered from severe sicknesses. Between the ages of 19 and 30 years, severity of sickness did have the effect of bringing down the proportions of never treated sicknesses for girls (from 21.4 per cent to 11.7 per cent) but the proportion of discontinued treatment among them increased. In the end, women were worse off than men. Among men, the proportion of never treated sicknesses reduced from 12.5 per cent to 7.5 per cent. Between the ages of 31 and 45 years, increased treatment-seeking by both men and women for severe sicknesses decreased the sex differential but only slightly. Even so, nine per cent of the severe sicknesses reported by women were never treated.

This pattern of relative male advantage continued to hold good among the elderly as well, although the differential did reduce when both suffered from severe sicknesses. Treatment-seeking increased among both men and women, but in the end women still had never treated sicknesses to the extent of 9.9 per cent. This discussion highlights the fluidity of inequalities over a lifetime, and of shifting axes of power.

5.3 Gender and marital status-based inequalities

5.3.1 Short-term sicknesses: Gender differences by marital status

As shown in Table 5.2, currently married women had poorer access to health care for short-term sicknesses than those who were unmarried, widowed or *devadasis*. Only 85 per cent of their sicknesses were ever treated. Self-censorship was the major reason cited for non-treatment,⁵⁷ followed by the fact that treatment was too expensive. Separated/ deserted women had even poorer access, as only 77.8 per cent of their sicknesses were ever treated. Censorship by self and by family members was the main reason why three out of four sicknesses were never treated.

Married and separated women might have had poorer access to health care due to their relatively poor status and bargaining power within the household. Most of those who suffered from lack of acknowledgement probably did not have direct access to incomes as well, as they mainly did housework or were self-employed.

Marital status made little difference to the men though, as they enjoyed high levels of unconditional access. The few who were denied treatment were directly confronted with economic barriers ("treatment too expensive"). Most of the men reporting economic barriers were non-earning members of the family. In contrast, most of the married women reporting economic barriers were casual wage earners themselves, or were self-employed. However, household poverty⁵⁸ and possibly, their own inability to use their earnings for their own needs might have resulted in treatment being denied.

This clearly illustrates how differently the barriers to access operated for women and men: women encountered economic barriers only when they earned incomes themselves, while men were able to overcome the initial barriers to access regardless of their own role in the household. This is why they were directly confronted with economic barriers that ultimately resulted in denial of treatment.

⁵⁷ The women called their sickness "non-serious" despite the fact that nearly three out of five of them were severe enough to make daily routines difficult.

⁵⁸ The major source of income for most of their households was casual wages.

5.3.2 Long-term sicknesses: Gender differences by marital status

Currently married women, most of whom were the wives of male heads of household, had the poorest access to treatment for long-term sicknesses compared to unmarried, separated, and widowed women, as well as all categories of men. Only 51.2 per cent of their sicknesses were being treated on the date of the survey.⁵⁹ The ineffectiveness of treatment that prompted them to say, “not getting cured” was the main reason for its discontinuance. Married men, on the other hand, enjoyed relatively

greater access with 71.2 per cent of their sicknesses being treated on the date of the survey. Those who were denied treatment were constrained by economic barriers. Clearly, married men and women experienced barriers to access differently.

Widows were also worse off than widowers as only 67.5 per cent of their sicknesses were continuing to be treated, compared to 86.3 per cent of those reported by the men – a difference of 27.8 per cent. The sex differential favoured men among those currently married and widowed. But for the others, the sex differential favoured women.

Table 5.2: Sex differences in access to health care by marital status

	Short-term sicknesses					Long-term sicknesses				
	Girls/women		Boys/men		Differences (N2-N1)/N1%	Girls/women		Boys/men		Differences N2-N1%
	N1	%	N2	%		N1	%	N2	%	
Ever treated										
Never married	2250	95.3	3204	96.4	1.1					
Currently married	3275	85.0	2606	95.6	12.5					
Separated/divorced	112	77.8	8	100.0	28.6					
Widowed	1199	90.4	132	100.0	10.6					
Devadasi	97	92.4			-100.0					
Currently treated										
Never married						576	68.0	669	59.3	-12.9
Currently married						1983	51.2	2024	71.2	39.0
Separated/divorced						148	70.5	24	60.0	-14.9
Widowed						938	67.5	151	86.3	27.8
Devadasi						24	43.6	0	0.0	-100.0
Discontinued treatment										
Never married						167	19.7	421	37.3	89.1
Currently married						1444	37.3	638	22.4	-39.8
Separated/divorced						31	14.8	0	0.0	-100.0
Widowed						285	20.5	24	13.7	-33.2
Devadasi						15	27.3	0	0.0	-100.0
Never treated										
Never married	110	4.7	120	3.6	-22.5	104	12.3	39	3.5	-71.9
Currently married	579	15.0	119	4.4	-70.9	445	11.5	182	6.4	-44.3
Separated/divorced	32	22.2	0	0.0	-100.0	31	14.8	16	40.0	171.0
Widowed	127	9.6	0	0.0	-100.0	166	12.0	0	0.0	-100.0
Devadasi	8	7.6			-100.0	16	29.1	0	0.0	-100.0

Note: Percentages are over the total number of sicknesses within each marital status category

⁵⁹ Not only did they have higher levels of discontinued treatment than most of the others (37.3 per cent), they also had relatively high levels of untreated sicknesses.

Chapter 6

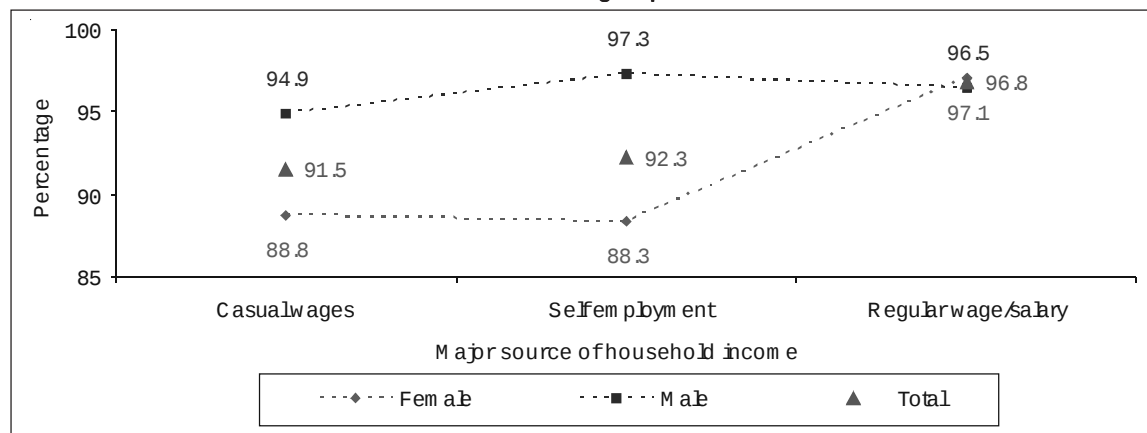
Structural inequities in access to health care: Inter-household differences

6.1 Gender and class-based inequities

Among the indicators of class outlined at the beginning, the ownership of fixed assets like land and housing did not seem to show any clear relationship with access to health care, depicted in terms of treatment-seeking status. In contrast, when economic class was represented as the major source of household income, a clearer set of relationships became evident. For this reason, we use income as an indicator of class.

earned regular incomes. The decline in ever-treated sicknesses between them was 8.5 per cent⁶⁰ as shown in Table 2 (Annexure 4). Interestingly, they had similar levels of access in casual wage earning and self-employed households: the difference in the proportions of ever-treated sicknesses was a negligible 0.5 per cent. And yet, women experienced the barriers to access differently in both these types of households. In self-employed households, women were constrained to a very

Figure 6.1: Short-term sicknesses: Percentage distribution of individuals ever treated by sex and income group



6.1.1 Short-term sicknesses: Gender differences by income

Overall, the households that earned regular wages were better off in terms of their access to health care, than those that subsisted on casual wages, or self-employment. As shown in Figure 6.1, 96.8 per cent of the sicknesses reported in such households were ever treated, compared to 91.5 per cent in casual wage earning, and 92.3 per cent in self-employed households. However, income made little difference to men, who enjoyed uniformly high levels of access in any type of household.

Women, on the other hand, had poorer access to health care in households that were dependent on casual wages, than in those that

large extent by the lack of acknowledgement by self and by the family. In contrast, women in casual wage earning households mainly reported that treatment was “too expensive.” The problem of acknowledgement did exist for them, but to a relatively smaller degree.

Due to these reasons, there were substantial differences between women and men in their access to health care in such households. Overall, the proportion of ever-treated sicknesses among men was 10.2 per cent higher in self-employed and 6.9 per cent higher in casual wage earning households. These differences did reduce when their sicknesses were severe enough to cause difficulty in daily functioning, as shown in Table 3 (Annexure 4).

⁶⁰ From 97.1 per cent in households that earned regular wages to 88.8 per cent in those that subsisted on casual wages.

In casual wage earning households, this reduction was from 10 per cent when the sickness was non-severe, to 5.3 per cent when it was severe. This is due to increased treatment-seeking by girls/women; but even so, they had twice as many untreated sicknesses (9.8 per cent) than men (5 per cent).

In self-employed households, on the other hand, inequities persisted⁶¹ despite changes in treatment-seeking. Many more women did seek treatment, but could not catch up with men, who also sought more treatment. In the end, they were left with a substantially larger pool of untreated sicknesses (9.7 per cent as against 1.5 per cent among men).

6.1.2 Long-term sicknesses: Gender differences by income

As shown in Figures 6.2 (a-c) and in Table 4 (Annexure 4), regular wage earning households were, once again, substantially better off than casual wage earning or self-employed households. Not only were there more persons currently being treated in these households, the proportions discontinuing treatment or never treated were also substantially smaller. This pattern was evident for both men and women. Treatment-seeking was

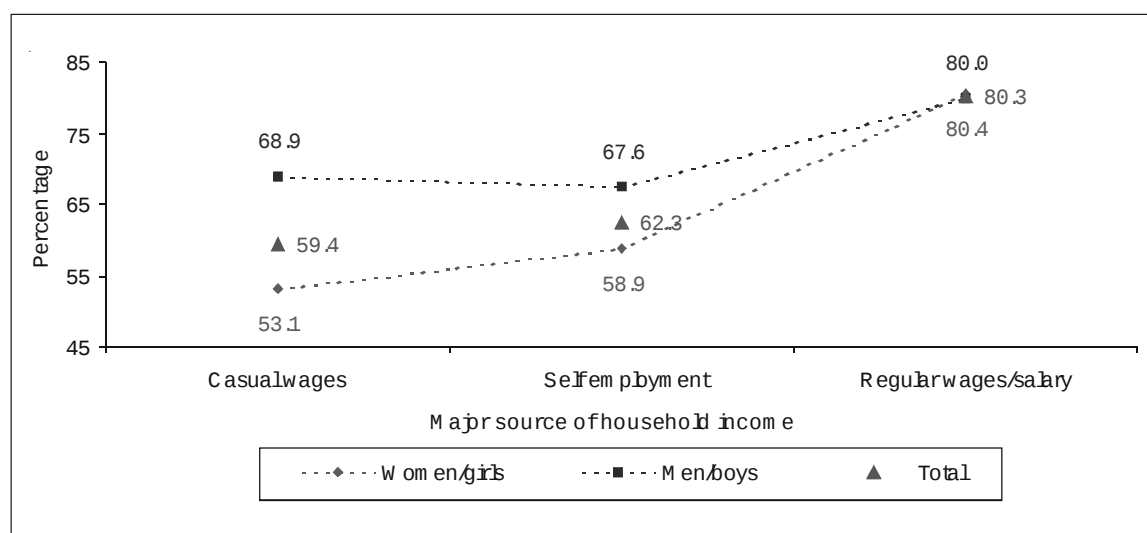
lower in self-employed and casual wage earning households for both men and women, and women had consistently poorer access to health care than men.

Sickness severity did contribute to a reduction in the sex differential, but only in casual wage earning households, as shown in Table 5 (Annexure 4). On the other hand, in self-employed and regular wage earning households, inequalities actually widened.

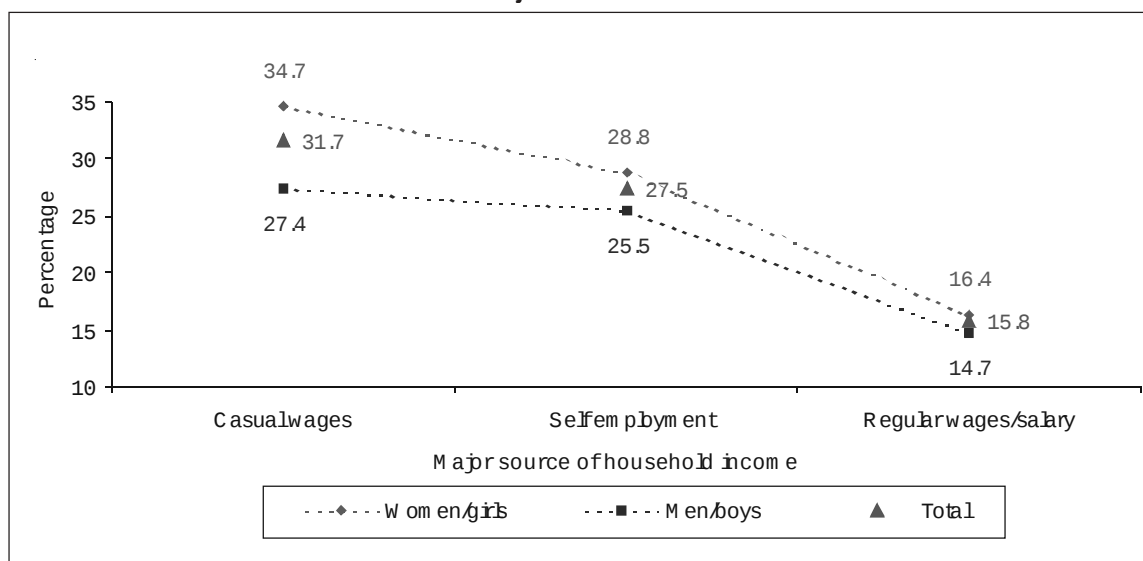
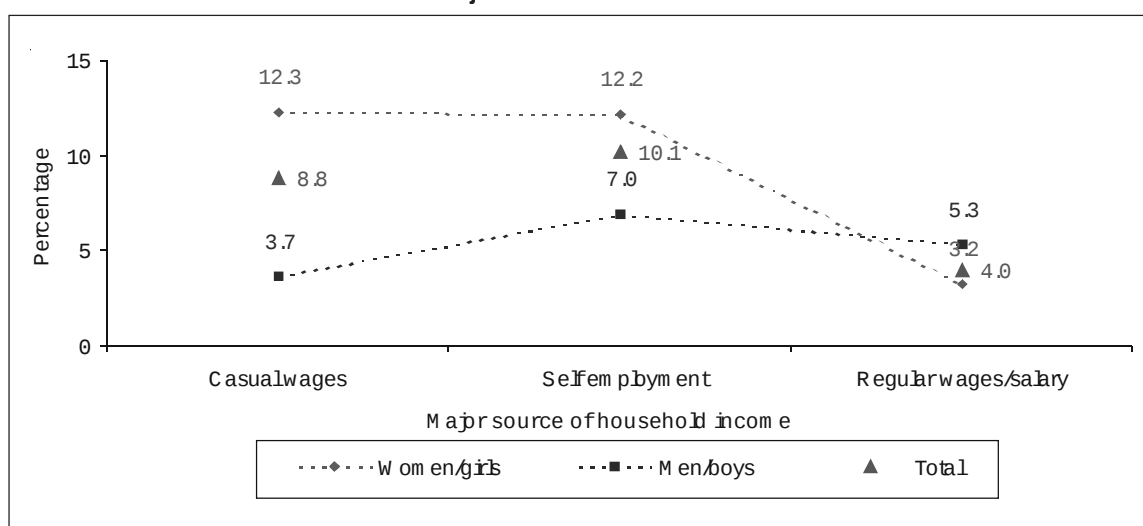
In self-employed households, this was linked to greater treatment-seeking by men, but unchanged treatment-seeking by women. Women in these households were constrained by the problem of acknowledgement and dissatisfaction with ineffective treatment when the sickness was non-severe; when it was severe enough to cause difficulties, (a lack of) acknowledgement continued to exist, but a substantial proportion now reported that treatment was too expensive.

In regular wage earning households, on the other hand, this was caused by a larger proportion of boys/men dropping out of treatment, so that the proportion continuing with treatment was substantially lower at 69 per cent, as against 87.7 per cent among girls/men. This is clearly an exception, and given the problem of small numbers,

Figure 6.2a: Long-term sicknesses: Percentage distribution of individuals currently being treated by sex and major source of household income



⁶¹ The reduction in the sex differential was insubstantial: from 11.5 per cent when the sickness was non-severe to 9.1 per cent when it was severe.

Figure 6.2b: Long-term sicknesses: Percentage distribution of individuals discontinuing treatment by sex and major source of household income**Figure 6.2c: Long-term sicknesses: Percentage distribution of individuals never treated by sex and major source of household income**

could reflect individual circumstances and actions, rather than group behaviour.

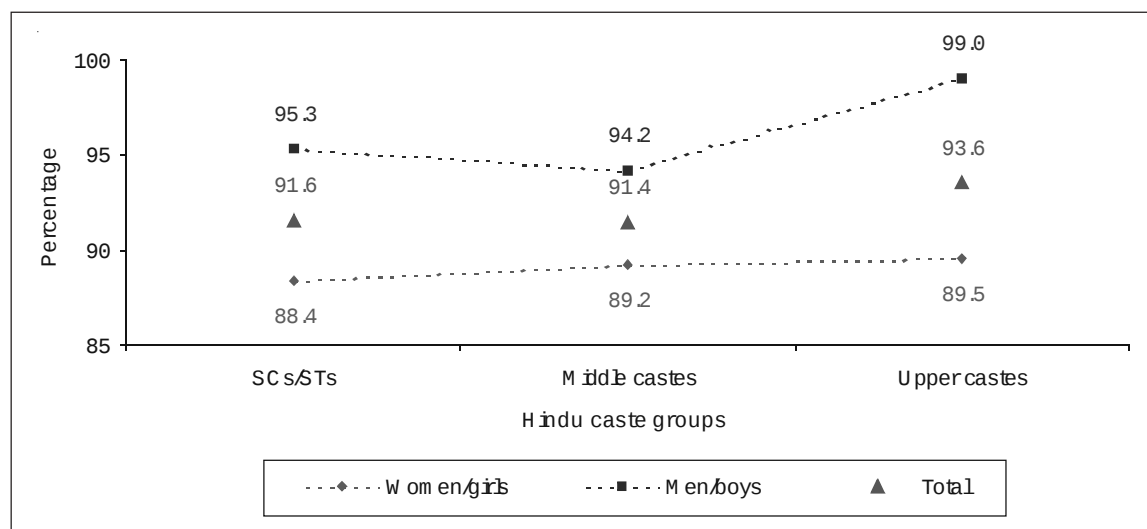
6.2 Gender and caste-and class-based inequities

6.2.1 Short-term sicknesses: Gender differences by caste

Caste hierarchies in Koppal are sharply defined and work adversely against the lower castes, especially women. However, caste did not appear to be a significant marker of inequality in access to health care for short-term sicknesses as

shown in Figure 6.3. The differences among men across caste groups were insubstantial. For instance, 99 per cent of all upper caste men were ever treated for a short-term sickness. But so were 95.3 per cent of all SC/ST men and 94.2 per cent of all middle caste men. The differences among women were even more miniscule: for example, 89.5 per cent of all upper caste women were ever treated, as were 88.4 per cent of all SC/ST women.

The data does, however, show substantial differences between men and women within each caste group and across groups. Even middle caste

Figure 6.3: Short-term sicknesses: Percentage distribution of individuals ever treated by sex and caste groups

men who had relatively lower access than upper caste and SC/ST men, were better off than upper caste women. Women across the board had relatively poor access compared to men. The differences were greatest between upper caste men and women, as shown in Table 6 (Annexure 4), due to the very high level of treatment-seeking among upper caste men.

6.2.2 Short-term sicknesses: Gender differences by caste and income

As shown in Table 7 (Annexure 4), the introduction of income groups within each caste results in increased inequities among men and women separately. For example, most upper caste women who lived in households that earned a regular wage or salary, sought treatment for short-term sicknesses (95 per cent). However, not as many upper caste women were able to seek treatment in self-employed or casual wage earning households (88.9 per cent and 88.8 per cent respectively). This shows that the economically better-off women within each of the caste groups sought more treatment for short-term sicknesses than the poor. Income was an important factor affecting variance. These inequalities between regular wage earning and self-employed / casual wage earning households were sharper among middle caste and SC/ST women. This shows that economic status

made a bigger difference to middle caste and SC/ST women than it did to the upper castes. But these differences would have to be tested before a definitive statement can be made.

The story was slightly different for men. Economic status made virtually no difference to upper caste men, who enjoyed unconditional access in all households. Even though fewer upper caste men were ever treated in casual wage earning households, this proportion (96.1 percent) was not substantially lower than that for men in regular wage earning and self-employed households (100 percent).

Economic status did appear to make some difference to SC/ST and middle caste men, however, although in different ways. While the trend for SC/ST men follows the one described so far,⁶² it was reversed in the case of middle caste men for whom treatment-seeking was much lower, in fact, in regular wage earning households. As these numbers are small, however, they may represent exceptional individual actions, rather than a group norm.

6.2.3 Short-term sicknesses: Gender differences by caste and severity of sickness

Table 8 (Annexure 4) shows that the proportion of ever treated sicknesses among men and women increased when they were severe enough to cause difficulty in daily functioning.

⁶² The proportion ever treated in casual wage earning households was 5.4 per cent lower than that in regular wage earning households, and 3.8 per cent lower than that in self-employed households.

Middle and upper caste women, in particular, sought more treatment when their sicknesses were severe, while fewer additional men in these groups sought treatment. Despite this, women had substantially more untreated sicknesses than men.⁶³ This is another reflection of how unconditional access to health care was for men. As a result, the sex differential narrowed substantially between middle caste men and women (from being 9.6 per cent higher among men when the sicknesses were non-severe to 2.9 per cent when the sicknesses were severe). It did narrow between upper caste men and women (from 15.7 per cent when the sicknesses were non-severe to 8.4 per cent when they were severe enough to cause difficulties), but a substantial gap continued to exist despite it.

The inequality between SC/ST men and women, on the other hand, remained unchanged, even when both suffered from severe sicknesses. The proportion of ever-treated severe sicknesses among men remained 7.6 per cent higher than among women, whereas this difference was 8.1 per cent when the sicknesses were non-severe. And 11.3 per cent of the sicknesses among the women went untreated, despite the difficulties caused in daily functioning.

Thus, severity of sickness had the impact of increasing access to health care for women, and of reducing the sex differential; however, it had the weakest impact on access to health care for SC/ST women who were triply disadvantaged in terms of the gender, caste, and class hierarchy. The lack of acknowledgement by the family (27.3 per cent) and by self (18.2 per cent) was one of the major reasons for untreated non-severe sicknesses; economic barriers constituting the other major barrier to treatment (36.4 per cent). When the sickness was severe, treatment was denied once again by lack of acknowledgement by *self* (39.9 per cent), rather than by family members. Economic barriers were evident once more but to a relatively smaller extent (29.7 per cent). This indicates that SC/ST women were held hostage by inimical gender-biased norms that ultimately worked to their detriment.

6.2.4 Long-term sicknesses: Gender differences by caste

In Figures 6.4 (a-c) and Table 9 (Annexure 4), we see the emergence of differences among men across caste groups when they suffered from long-term sicknesses. While these differences were more substantial than before, they were still not striking. The differences among women across caste groups were less substantial than among men.

These small differences worked in an expected fashion for women who were never treated. Disadvantages progressively increased as one went down the caste hierarchy. The percentage of never treated sicknesses did go up between upper caste and middle caste women, even if it was by a mere 2.3 per cent. The rate of increase was more sharply defined between middle caste and SC/ST women who had 26.5 per cent more sicknesses that were never treated. Between upper caste and SC/ST women, the increase in never treated sicknesses was 29.4 per cent.

However, the distribution of currently treated sicknesses did not follow this pattern. The percentage of currently treated sicknesses was lowest among middle caste women, mainly due to a higher proportion of their treatment being discontinued.⁶⁴ The main reasons for discontinuance – disillusionment with treatment and the fact that even this ineffective treatment was expensive – were not different from those given by upper caste and SC/ST women. Nor was it the case that middle caste women had a higher proportion of non-severe sicknesses. The middle caste women who discontinued treatment did, however, come from households that had three sick persons on average; and as we saw earlier, the number of sick persons in the household was a significant predictor of the capacity of middle caste households to secure treatment-seeking for all of its members. This could possibly have contributed to limited support for their treatment.

Additionally, their poor access could also reflect their social location in the household, which forms the basis for their bargaining power within

⁶³ The proportions of untreated sicknesses were 8.4 per cent and 7.6 per cent among upper caste and middle caste women respectively. In contrast, the proportions of untreated sicknesses among the men were 0.7 per cent and 4.9 per cent respectively.

⁶⁴ As a result, while there was a 19.3 per cent increase in the sicknesses for which treatment was discontinued between upper and middle castes, there was an almost equivalent drop of 15.7 per cent between middle caste and SC/ST women. As a result, the difference overall between upper caste and SC/ST women was virtually non-existent.

the household. As 36-year-old wives of household heads in self-employed households, more than 88 per cent illiterate, most either non-income earners or casual wage earners, their social location was as precarious as SC/ST women. These two factors together might have resulted in inimical access.

Middle caste men too were slightly worse off than upper-caste men and this could be

expected, given their poorer economic status overall. However, the surprising finding lies in the very high levels of treatment-seeking among SC/ST men, which was substantially better than men in other caste groups. As many as 73.7 per cent of their sicknesses were continuing to be treated. This proportion was 8.9 per cent higher than that for upper caste men and 12.7 per cent higher than that for middle caste

Figure 6.4a: Long-term sicknesses: Percentage distribution of individuals currently being treated by sex and caste groups

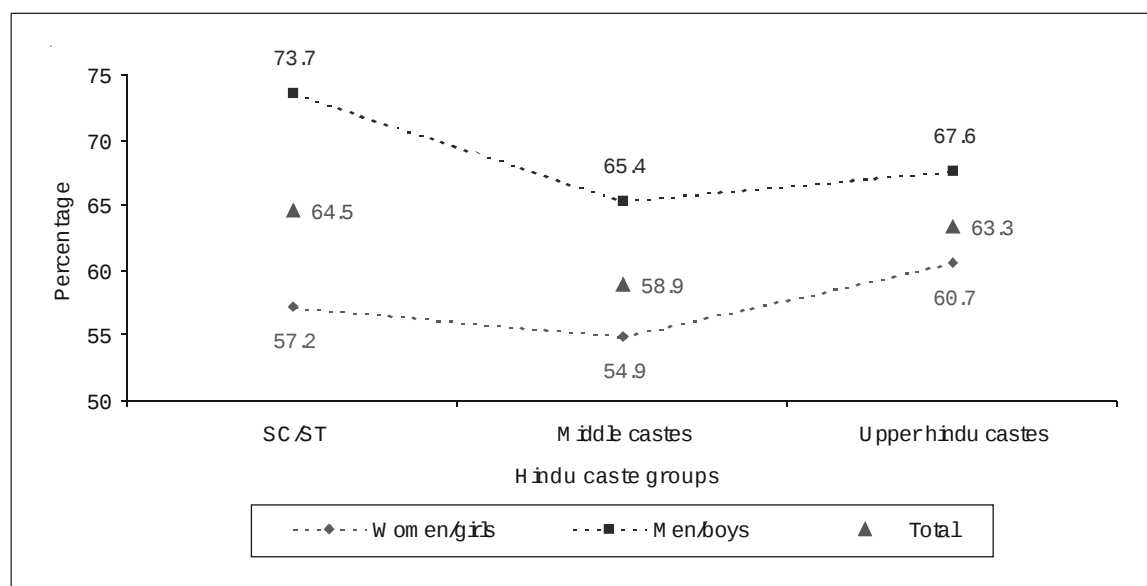


Figure 6.4b: Long-term sicknesses: Percentage distribution of individuals discontinuing treatment by sex and caste groups

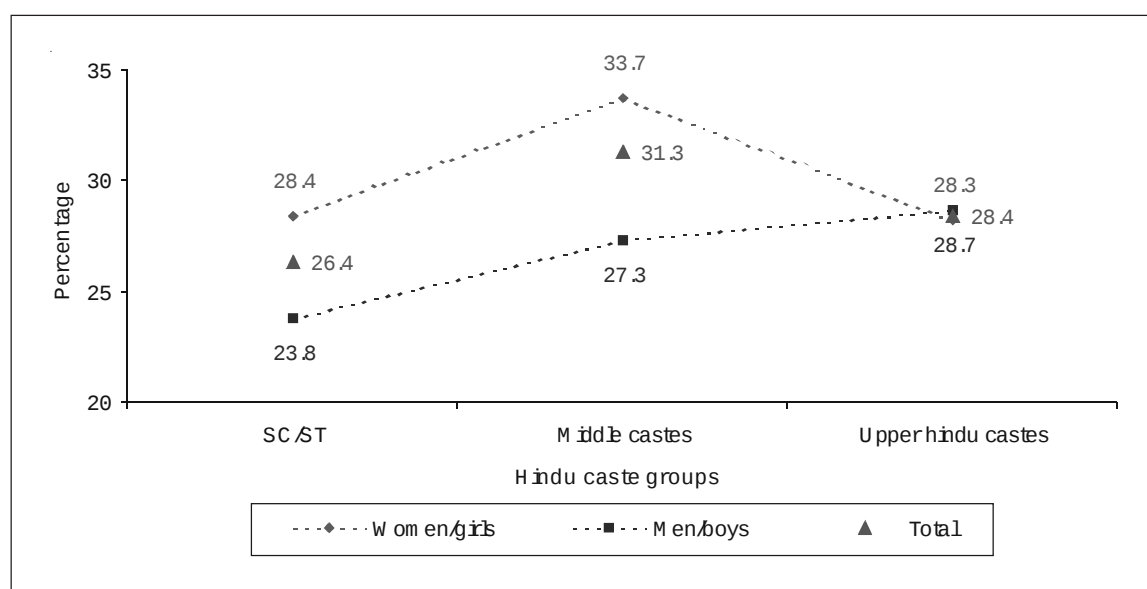
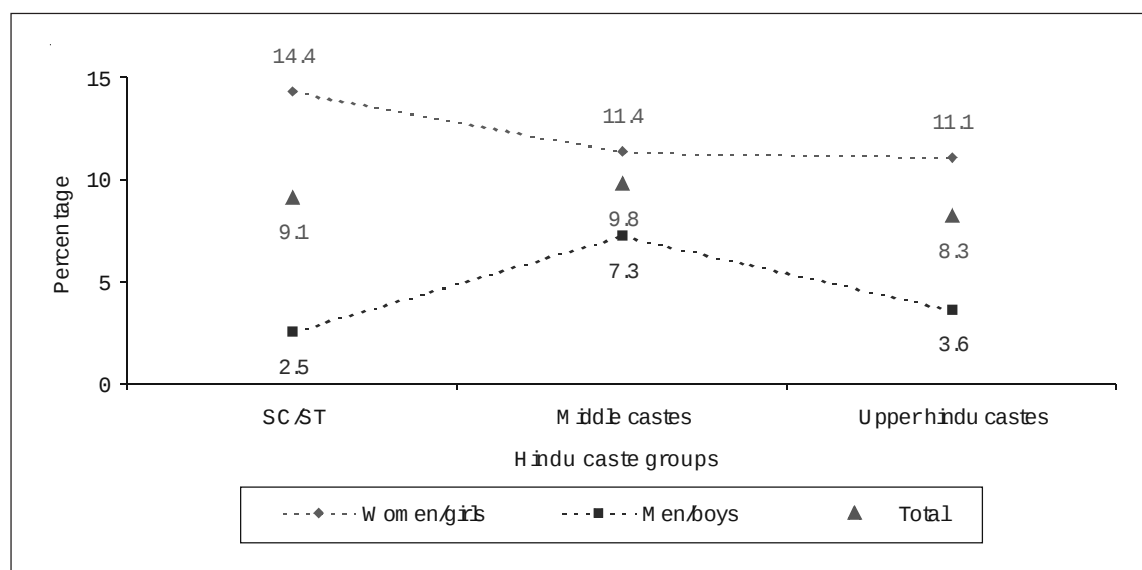


Figure 6.4c: Long-term sicknesses: Percentage distribution of individuals never treated by sex and caste groups



men. Similarly, the percentage of never treated sicknesses among them was 30.9 per cent lower than upper caste men and 65.3 per cent lower than middle caste men. Were SC/ST men seeking long-term treatment from public health providers? Was an extended period of treatment-seeking initially set off by an injury or accident, which is known to be fairly common among the poor? Further analysis is required in order to understand the specific reasons for the seemingly better access to health care among SC/ST men.

This position of seeming privilege did not extend to SC/ST women who had the poorest access to care overall. As a result, the sex differential was highest between SC/ST men and women: the percentage of currently treated sicknesses was 28.7 per cent higher than the women, and that of never treated sicknesses 82.5 per cent lower. Similarly, fewer upper and middle caste women (60.7 per cent and 54.9 per cent respectively) were undergoing treatment on the date of the survey than upper and middle caste men (67.6 per cent and 65.4 per cent respectively). In other words, although the differences for men and women separately may not have amounted to much, women across the board were worse off than men.

These sex differentials progressively increased in middle caste and SC/ST households. The percentage of sicknesses currently being treated was

11.5 per cent higher among upper caste men than women; it grew to 19 per cent among the middle castes and 28.7 per cent among SCs/STs. This reflects, once more, the highly disadvantaged position that SC/ST women were in vis-à-vis access to health care.

6.2.5 Long-term sicknesses: Gender differences by caste and income

Although the differences among women across the caste groups were insubstantial, differences between women within each caste group began to start showing up when caste combined with class. This is shown in Table 10 (Annexure 4). For example, most upper caste women who lived in households that earned a regular wage or salary were being “currently” treated for long-term sicknesses (81.7 per cent). However, not as many upper caste women were being treated in households that were self-employed (61.2 per cent, 25.1 per cent lower than upper caste women). This percentage dropped even further for women who lived in households that subsisted on casual wages (53.2 per cent, 13.1 per cent lower than those earning from self-employment, and 34.9 per cent lower than those earning regular wages).

This tendency for treatment-seeking to drop sharply from a very high level in households that earned regular wages to substantially lower levels in those that earned an income from self-

employment or casual wage labour held for middle caste women as well. This shows that being economically better off within the first two caste groups meant better access to treatment for long-term sicknesses. For SC/ST women, however, this logic did not hold out. The proportion seeking treatment in households that earned a regular wage was actually extremely low (50.1 per cent). The explanation for this disjuncture is to be found in their relatively poorer social location within the household, and the fact that it did not help them even when the household was privileged enough to earn regular wages.

The introduction of economic class categories within each caste group did not have the same effect for men as it did for women. For SC/ST men, this sub-division made little difference to their numbers. The proportion of those continuing with treatment was 80 per cent for those living in households that earned a regular wage. This proportion reduced, but not tremendously, in households that were self-employed (75.5 per cent, 5.7 per cent lower) and those that subsisted on casual wages (72.8 per cent, 3.6 per cent lower than those that earned from self-employment, and 9% lower than those that earned regular wages).

For upper caste men, on the other hand, there were differences in the proportion of currently treated sicknesses between those who lived in households that earned a regular wage (79.7 per cent) and those that subsisted on casual wages (59.9 per cent, a decline of 25 per cent). Among middle caste men, there was an interesting and quite substantial increase in the percentage of currently treated sicknesses – an increase of 14 per cent – in casual wage earning households compared to those that earned from self-employment. Again, explanations will have to be found for this interesting pattern.

6.2.6 Long-term sicknesses: Gender differences by caste and severity of sickness

As shown in Table 11 (Annexure 4), treatment-seeking increased for both men and women, and in all caste groups, when their sicknesses were severe enough to cause difficulty in daily functioning. However, the increases were neither uniform nor did they follow a steady progression. Many more upper caste and SC/ST women, and middle caste and SC/ST men sought treatment but the net effect on existing inequalities was not the same for all castes. Increased treatment-seeking for severe sicknesses resulted in obliteration of the sex differential between upper caste men and women. In other words, upper caste women were able to catch up with upper caste men whose percentages actually reduced. However, the sex differential increased tremendously between middle caste men and women⁶⁵ owing to much higher treatment-seeking by the men. Between SC/ST men and women, severity of sickness did result in more treatment-seeking by women, but they simply could not catch up with men, many more of whose sicknesses were treated. As a result, the sex differential remained constant at around 28 per cent. In the end, 11.1 per cent of their sicknesses were never treated, which is higher than the proportions among upper and middle caste women (8.7 per cent and 9.9 per cent respectively), and upper-, middle- and SC/ST men (5.1 per cent, 5.4 per cent and 0 per cent respectively).

Once again, this reflects the extremely disadvantaged position that SC/ST women occupy compared to other women, and certainly other men. Their access to care was conditional and limited, and even severity of sickness could not prompt access to health care.

⁶⁵ The proportion of currently treated sicknesses was 9.6 per cent higher among middle caste men when both had sicknesses that were not severe; this increased to 25.2 per cent when both had severe sicknesses.

Chapter 7

Conclusion

Growing empirical evidence in the health and development literature indicating that out-of-pocket health care expenditures contribute significantly to poverty makes a study of access to health care and affordability topical and necessary. Access to health care was an important issue for most households in Koppal. 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.

These inequities were more sharply defined in treatment-seeking for long-term sicknesses that extended for two years (on average). In contrast, there was comparatively more treatment-seeking for short-term sicknesses that lasted for eight days (on average), and smaller differences by sex, caste, class, age and membership status of kinship groups. This might be linked to the efforts to restore health in a context where everybody is expected to work towards family maintenance.

In prioritising treatment-seeking, households seem to have responded to a range of considerations. We considered two of these in our analysis: severity of the sickness and the social location of the sick person. Using these criteria, we venture to say that 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.

The analysis points to the fact that inequities could be fluid and situation specific, at times, even though they are defined within a set of more enduring parameters. For example, they changed over a lifetime from being adversely poised against boys during early and late childhood to working against girls/women during the

reproductive and older age groups. They were also affected by life events like marriage, which worked adversely against women in their natal homes, but favourably for men. Yet, even as daughters-in-law and spouses, these women had relatively poor access than husbands, and mothers-in-law, even when they suffered from severe sicknesses.

The multifaceted axes of inequality were clearly interlinked and the nature of their interrelationships gave rise to a number of scenarios. When the entitlements emanating from one reinforced the other, the net result was highly positive. This is illustrated by the tremendous advantage that upper caste males had when they lived in regular wage earning households. When the (dis)entitlements deriving from one axis reinforced the (dis)entitlements prescribed by the other axes, the net result was highly negative. For example, SC/ST women in casual wage earning households, who were triply disadvantaged by their gender, caste and class, were the worst off. But when the entitlements emanating from one axis countered the (dis)entitlements emanating from other axes, there were mixed results. For example, upper caste women in casual wage earning households did not fare as well as those in regular wage earning households. Middle caste women suffering from long-term sicknesses were worse off than SC/ST women too because of their adverse social location and the fact that there were already three sick persons in their households on average.

However, the axes also had fixed effects at times; an observation that is illustrated by the way in which the response to severity of sickness among SC/ST men and women remained unchanged. As a result, SC/ST women continued to have adverse terms of access to health care while the men did not.

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 but SC/ST men were relatively better off than other men. This itself could be a manifestation of the multifaceted nature of inequities – both intra- and inter-household.

Finally, women and men experienced economic barriers differently. Apart from marginalised 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 focusing on acknowledgement and permission for treatment-seeking. 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.

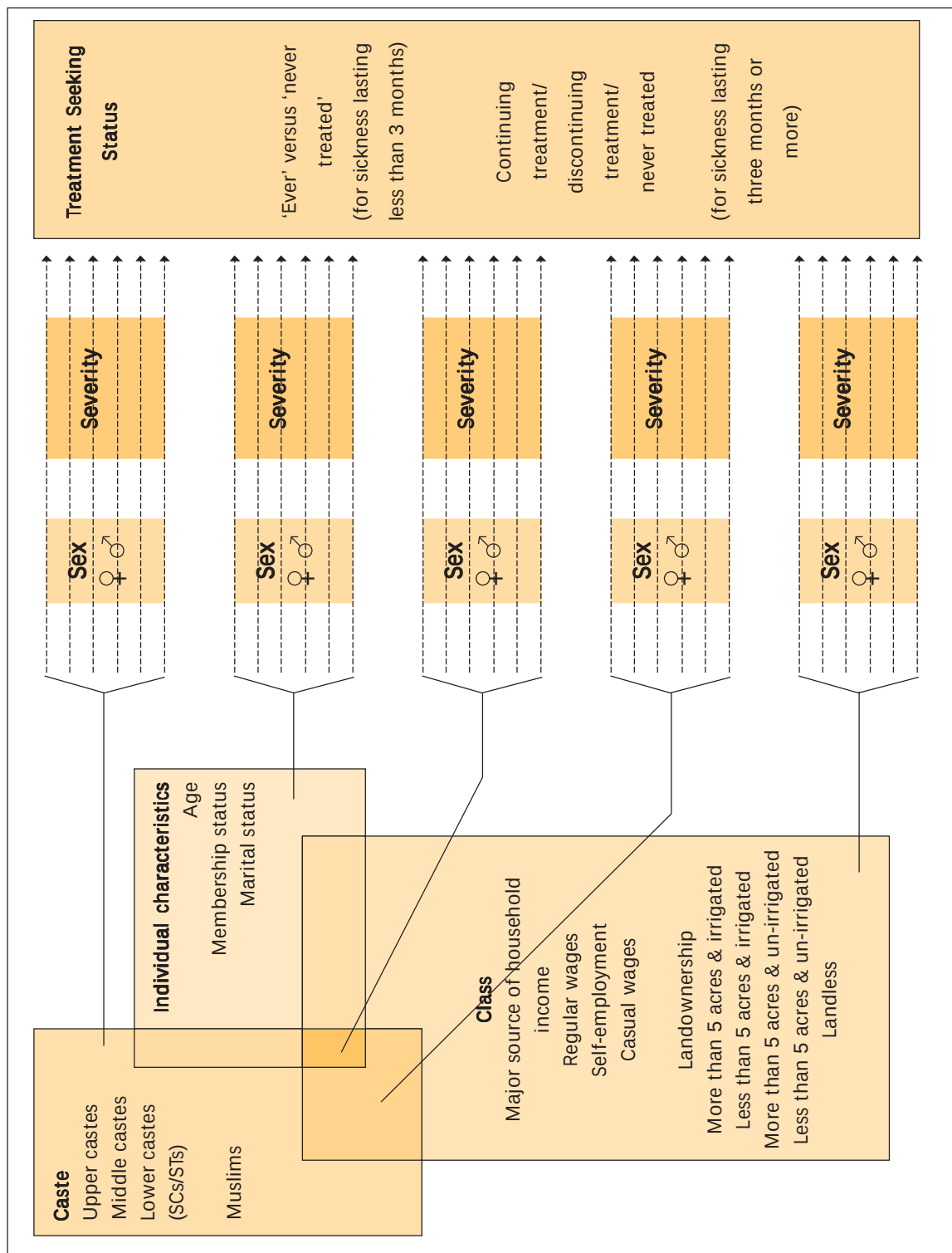
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Annexure 1

Organising framework



Gender and Health Equity Project (Baseline survey, June-July 2002)
Access to health care access, utilisation and expenditures:
Study of households in Koppal and Yelburga Talukas, Koppal District

Under Memorandum of Understanding between Indian Institute of Management Bangalore , Mahila Samakhya Karnataka and Health & Family Welfare Department (Government of Karnataka)

Dear Respondent,

We are doing a study to understand your health and what you do to take care of it. This is the beginning of a three-year project that aims to improve your community's health awareness and access to care. It seeks to improve communication and planning between communities and the local government health services. This will involve collaboration between your community, the Health Department, Mahila Samakhya, and the Indian Institute of Management Bangalore.

We need to understand the experience of your village, but we can't talk to everybody. It is like when you want to check if a pot of rice is cooked, you don't need to check every grain. You need only to select a few. We gave numbers to every house in your village and then picked out a few with our eyes closed, so that we would not know who would get selected. There is no other reason why your house was selected.

We kindly request your cooperation with this study. Some questions need to be answered jointly by several household members, some questions will need to be answered by men and women separately. As health is linked to many factors, we will also be asking you about your daily life (like for example your work, education, housing, how much you spend on food, health care, etc). There are no right or wrong answers. Your opinions and experiences with health are very important to us. Your answers will help design project activities for your community.

Please feel free to ask questions to the interviewer if you don't understand any of the questions. Your cooperation is purely voluntary. You have the right to not answer certain questions if you don't want to. If for any reason, you wish to end the interview at any point, you have the right to do so.

The information we collect will be kept confidential. All names of people and places will be removed when presenting information. At the end of the survey, we will provide a summary of the information collected to your community. Thank you for your time and cooperation.

For any clarifications or for further information, please contact IIMB and/or Mahila Samakhya Karnataka, Koppal.

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Bannerghatta Road
Bangalore 560 076
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Gender and Health Equity Project (Baseline survey, June – July 2002)
Access to Health Care, Utilisation and Expenditures:
Study of households in Koppal and Yelburga talukas, Koppal district

1. Enumeration No.									
2. PHC Cluster 	Hirewankalkunta	1		Kuknoor	4		Irkalgada	7	
	Mangalore	2		Ginigera	5		Kinhal	8	
	Sanganhal	3		Kukanpalli	6				
3. Household Serial No.						4. Sample Serial No.			

5. Date & duration of interview:

1st visit: Date: / /

2nd visit: Date: / /

3rd visit: Date: / /

Time: Starting Finishing

Time: Starting Finishing

Time: Starting Finishing

6. Interviewer ID No.

Name:

Signature:

Name:

Signature:

7. Number of modules filled:

1

2

3

4

5

Sr. Nos of Respondents	Module 1	Module 2	Module 3	Module 4	Module 5

8. If household substituted, reason: Household locked & members away 1 Refusal 2

9. Substitution authorised by: Name: Signature:

10. Questionnaire checked by: Name: Signature:

Module 1: Details about individuals in the household

1. Name of Main Respondent:

2. Sr. No.:

Sr. No.	Name	Relationship to head of household	Age in completed years	Sex:	Marital Status	Currently studying? (includes formal and non-formal education)	If age 5-14 and not currently studying, why not?	Education completed	Main activity in the last 365 days	Pregnant at any time last 365 days?	During the last 30 days did the person suffer from any illness? Use Probe List
3	4	5	6	7	8	9	10	11	12	13	14
1.		1									
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											

"Relationship" (col. 5)

Head of house hold	01	Mother, father	07
Spouse	02	Mother/father-in-law	08
Married child	03	Sister, brother	09
Spouse of married child	04	Sister/brother-in-law	10
Unmarried child	05	Servant, employee	11
Grandchild	06	If Other, please specify	96

"Age in completed years" (col. 6)

Less than 1	01	25 to 29	07
1 to 4	02	30 to 34	08
5 to 9	03	35 to 44	09
10 to 14	04	45 to 54	10
15 to 19	05	55 + 11	
20 to 24	06		

"Why not in school" (col. 10) (main reason only)

Education unnecessary	01	Was married	07
Child uninterested in studies	02	Not safe	08
Education too expensive	03	School too far/no transport	09
Required for housework	04	No hostel	10
Required for other work	05	No teacher	11
Came of age/ menarche	06	If Other, please specify	96

"Education Completed" (col. 11)

Anganwadi	01	Std. 5-9, includes matric fail	04	If other	96
Illiterates	02	Matric pass & above	05	specify	
Below Std.5	03	Literates (non-formal education)	06		

"Main Activity" (col. 12)

Casual wage labour	01	Self employed	03	Housework	05	If other	96
Regular wage/salary earner	02	Studying	04	Too old or under 5 years	06	specify	

Sr. No.	Name	Relationship to head of household	Age in completed years	Sex:	Marital Status Never married 1 Currently married 2 Separated/divorced 3	Currently studying? (includes formal and non-formal education) Yes 1 No 2	If age 5-14 and not currently studying, why not?	Education completed	Main activity in the last 365 days	Pregnant at any time last 365 days?	During the last 30 days did the person suffer from any illness? Use Probe List Yes 1 No 2
3	4	5	6	7	8	9	10	11	12	13	14
11.		1									
12.											
13.											
14.											
15.											
16.											
17.											
18.											
19.											
20.											
21.											
22.											

"Relationship" (col. 5)						"Age in completed years" (col. 6)						"Why not in school" (col. 10) (main reason only)					
Head of house hold	01	Mother, father	07	Less than 1	01	25 to 29	07	Education unnecessary	01	Was married	07						
Spouse	02	Mother/father-in-law	08	1 to 4	02	30 to 34	08	Child uninterested in studies	02	Not safe	08						
Married child	03	Sister, brother	09	5 to 9	03	35 to 44	09	Education too expensive	03	School too far/no transport	09						
Spouse of married child	04	Sister/brother-in-law	10	10 to 14	04	45 to 54	10	Required for housework	04	No hostel	10						
Unmarried child	05	Servant, employee	11	15 to 19	05	55 + 11		Required for other work	05	No teacher	11						
Grandchild	06	If Other, please specify	96	20 to 24	06			Came of age/ menarche	06	If Other, please specify	96						

"Education Completed" (col. 11)				"Main Activity" (col. 12)			
Anganwadi	01	Std. 5-9, includes matric fail	04	If other	96		
Illiterates	02	Matric pass & above	05	specify			
Below Std.5	03	Literates (non-formal education)	06				