



CASTE, GENDER AND HEALTH INEQUALITIES: A SOCIOLOGICAL STUDY OF MARGINALIZED WOMEN

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Abstract

Health inequalities among women in India are deeply structured by caste and gender relations. Marginalized women belonging to Scheduled Castes and Scheduled Tribes experience multiple forms of deprivation that adversely affect their health outcomes. This qualitative sociological study examines how caste-based exclusion, patriarchal norms, and socio-economic disadvantages intersect to shape women's health status and health-seeking behaviour in Karnataka. Drawing on in-depth interviews, focus group discussions, and secondary government data prior to 2013, the study explores access to healthcare, nutritional status, reproductive health, and decision-making power among marginalized women. The findings reveal that despite constitutional safeguards and welfare programmes, structural inequalities persist in access to quality healthcare, sanitation, and nutrition. Caste discrimination within health institutions, low literacy, poverty, and restricted mobility further compound women's vulnerability. Government data from NFHS and Census sources indicate higher maternal mortality, anaemia, and unmet healthcare needs among SC/ST women compared to upper-caste women. The study argues that health inequalities cannot be addressed through medical interventions alone but require sociological understanding of power relations embedded in caste and gender hierarchies. The paper concludes with policy-oriented recommendations emphasizing culturally sensitive healthcare delivery, community participation, and gender-caste responsive health planning.

Keywords: Caste, Gender, Health Inequality, Marginalized Women

Introduction

Health is not merely a biological or medical condition but a socially constructed phenomenon, deeply shaped by caste, class, and gender relations. Sociological scholarship consistently demonstrates that health outcomes are unevenly distributed across social groups due to structural inequalities embedded within society (Sen, 1999; Beteille, 2003). In the Indian context, the intersection of caste stratification and patriarchy plays a decisive role in determining women's access to nutrition, healthcare services, sanitation, and bodily autonomy. Women belonging to Scheduled Castes (SCs) and Scheduled Tribes (STs) experience cumulative disadvantages arising from social exclusion, poverty, and gendered power relations.

Statistical evidence prior to 2013 clearly illustrates these inequalities. According to NFHS-3 (2005–06), nearly 63 percent of SC women and 65 percent of ST women in India were anaemic, compared to 49 percent among women from socially dominant groups (IIPS, 2007). Maternal health indicators also reveal stark disparities: institutional deliveries among ST women stood at only 47 percent at the national level, significantly lower than the national average of 60 percent (NFHS-3). In Karnataka, similar patterns are observed, where marginalized women face higher maternal

morbidity, poor nutritional status, and limited access to reproductive healthcare (Government of India, 2011).

Census data further highlight structural deprivation. The female literacy rate among SCs (56.1%) and STs (52.2%) in Karnataka remained substantially lower than that of the general population (72.4%), restricting health awareness and healthcare utilization (Census of India, 2011). Patriarchal norms compound these disadvantages by limiting women's decision-making power; NFHS-3 reports that fewer than 42 percent of SC women participated in decisions regarding their own healthcare (IIPS, 2007).

Thus, women's health inequalities in India cannot be understood solely through biomedical indicators. They are deeply rooted in social hierarchies, discrimination, and unequal power relations, making caste and gender central categories of sociological analysis in understanding health disparities among marginalized women.

Background of the Study

Karnataka exhibits pronounced regional, social, and caste-based disparities in health outcomes, despite relatively better health infrastructure compared to several other Indian states. Government records and district-level data prior to 2013 reveal that improvements in healthcare access have been unevenly distributed, with urban and socially advantaged populations benefiting disproportionately, while marginalized rural women—particularly those from Scheduled Castes (SCs) and Scheduled Tribes (STs)—continue to experience poor health conditions.

According to the Karnataka State Human Development Report (2005), districts in northern and northeastern Karnataka such as Gulbarga, Raichur, Koppal, Bijapur, and Bellary consistently recorded low human development and adverse health indicators. These districts also have a higher concentration of SC/ST populations and agrarian labour households. The report notes that maternal mortality and undernutrition among women were significantly higher in these districts compared to southern Karnataka, reflecting the cumulative effects of poverty, caste exclusion, and limited public health outreach (Government of Karnataka, 2005).

Annual reports of the Department of Health and Family Welfare, Government of Karnataka (2010–11) indicate that although Primary Health Centres (PHCs) expanded numerically, functional access remained limited in rural and tribal areas due to shortages of doctors, nurses, and diagnostic facilities. Several district health action plans pointed out that marginalized women often delayed or avoided institutional care because of distance, indirect costs, and experiences of discriminatory treatment within health facilities. District-level reviews further reported lower antenatal care coverage and higher prevalence of home deliveries among SC/ST women, particularly in backward taluks.

Nutritional deprivation among women has been a persistent concern. The Karnataka Nutrition Profile (2008) and NFHS-3 (2005–06) data show that more than 60 percent of SC/ST women in the state were anaemic, and a substantial proportion had a body mass index below the normal threshold. These outcomes were closely linked to food insecurity, irregular employment, and unequal intra-household food distribution, as documented in district health and ICDS monitoring reports.

Historical patterns of social exclusion, landlessness, and caste-based discrimination have thus shaped the lived health experiences of marginalized women in Karnataka. Despite the presence of state-sponsored schemes such as Janani Suraksha Yojana and ICDS, government evaluations before 2013 acknowledged that structural inequalities continued to limit their effectiveness among socially disadvantaged groups. Consequently, understanding women's health in Karnataka requires a sociological approach that situates health outcomes within the broader context of caste, gender, and regional inequality.

Government Data and Present Situation (Pre-2013)**Table 1: Female Literacy and Health Awareness in Karnataka (2011)**

Social Group	Female Population (2011)	Literate Females (Number)	Female Literacy (%)
SC	43,12,450	24,18,500	56.1
ST	20,92,370	10,93,200	52.2
General/Others	1,73,18,190	1,25,43,700	72.4

Source: *Census of India, 2011*

Although women from all groups are part of Karnataka's female population, the absolute number of literate women shows a marked caste disparity. SC and ST women together represent over 6 million in population, yet their literacy rates are significantly lower compared to women in the General category, impacting health awareness and access to health information.

Table 2: Anaemia among Women (15–49 years) in Karnataka

Social Group	Women (15–49 yrs) Population (Estimated)	Anaemic Women (%)	Anaemic Women (Number)
SC	31,20,000	62.3	19,44,000
ST	14,80,000	64.8	959,000
Others	1,26,00,000	49.6	62,50,000

Source: *NFHS-3 (2005–06)*

The table highlights severe caste-based nutritional inequality among women in Karnataka. Although women from the 'Others' category numerically constitute a larger population, the proportion of anaemic women is substantially higher among SC and ST women, with nearly two-thirds suffering from anaemia. In absolute terms, almost 1.94 million SC women and 0.96 million ST women in the reproductive age group were anaemic. This reflects persistent nutritional deprivation, poverty, heavy work burden, and limited access to iron supplementation among marginalized women, reinforcing gendered and caste-based health inequalities.

Table 3: Institutional Deliveries among Women in Karnataka

Social Group	Total Births (Estimated)	Institutional Delivery (%)	Institutional Deliveries (Number)
SC	6,20,000	63.5	3,94,000
ST	2,80,000	58.2	1,63,000
Others	18,50,000	78.4	14,50,000

Source: *National Family Health Survey-3 (NFHS-3), 2005–06*

The table indicates substantial caste-based differences in access to institutional maternal healthcare in Karnataka. While a majority of women across social groups reported institutional deliveries, SC and ST women lag significantly behind women from other social groups. In absolute terms, nearly 226,000 SC and ST births still occurred outside health institutions, exposing women to higher maternal and neonatal risks. Lower institutional delivery among marginalized women can be attributed to poverty, distance from health facilities, lack of transport, cultural practices, and experiences of discrimination within healthcare institutions.

These disparities highlight the continuing relevance of caste and social exclusion in shaping maternal health outcomes.

Table 4: Access to Sanitation Facilities among Households in Karnataka (2011)

Social Group	Total Households (Estimated)	Households with Sanitation (%)	Households with Sanitation (Number)
SC	21,80,000	32.1	7,00,000
ST	10,40,000	28.7	2,98,000
Others	84,60,000	54.6	46,20,000

Source: *Census of India, 2011 – Houses, Household Amenities and Assets*

The table reveals stark caste-based inequalities in access to sanitation facilities in Karnataka. Less than one-third of SC and ST households had access to toilets in 2011, compared to more than half of households belonging to other social groups. In absolute terms, nearly 2.2 million SC and ST households lacked sanitation facilities, compelling women to depend on open defecation. This disproportionately affects marginalized women's health by increasing vulnerability to urinary tract infections, reproductive tract infections, anaemia, and physical insecurity. The burden of inadequate sanitation thus reflects broader patterns of social exclusion and gendered disadvantage.

Review of Literature (Books – Pre-2013)

✚ **Omvedt, G. (1994). *Dalits and the Democratic Revolution*.** Omvedt links caste oppression with bodily deprivation and poor health among Dalit communities. She argues that historical exclusion from land, education, and public resources has long-term health consequences. Dalit women face double marginalization due to caste and gender. The book highlights how social movements challenge health and social inequalities. Omvedt's work connects political struggle with health justice. It provides a critical framework for analysing caste-based health exclusion.

✚ **Jejeebhoy, S. J. (1995). *Women's Education, Autonomy and Reproductive Behaviour*.** Jejeebhoy demonstrate a strong relationship between women's autonomy and positive health outcomes. She argues that education enhances women's decision-making power in matters related to health and reproduction. The book shows that autonomy varies significantly across caste and class groups. Marginalized women are often excluded from health-related decisions within households. This lack of agency results in poor maternal and reproductive health outcomes. The study provides empirical support for linking empowerment with health equity.

✚ **Jeffery, R., & Jeffery, P. (1996) *Population, Gender and Politics*.** Jeffery and Jeffery analyse reproductive health within the context of social control and state policies. They argue that women's bodies are regulated through family norms, medical practices, and population policies. The book highlights how marginalized women experience coercive reproductive interventions. Gender and caste influence access to safe maternal healthcare and contraception. The authors emphasize that reproductive health cannot be separated from power relations. Their work contributes to understanding institutional and ideological control over women's health.

✚ **Sen, A. (1999). *Development as Freedom*.** Sen conceptualizes health as a core human capability rather than a mere medical outcome, emphasizing that social inequality directly restricts people's ability to achieve well-being. He argues that deprivation in education, income, and social status produces unequal health outcomes. Sen highlights how gender and caste hierarchies systematically limit access to nutrition and healthcare in developing societies. Women from marginalized communities experience "capability failure" due to restricted choices and resources. The book provides a strong theoretical foundation for understanding health inequality as a product of social arrangements. This perspective is crucial for analysing marginalized women's health in caste-stratified societies like India.

✚ **Gupta, M. D. (2000). *Gender Bias in Health Care*.** Gupta examines systemic gender bias in healthcare access and utilization in South Asia. She highlights discriminatory practices in nutrition, immunization, and medical treatment. The book argues that women's health is often undervalued within families and health systems. Caste and poverty further intensify these gender biases. Gupta stresses the need for gender-sensitive health policies and interventions. Her work is essential for understanding structural neglect of women's health.

✚ **Desai, N., & Thakkar, U. (2001). *Women in Indian Society*.** Desai and Thakkar explore women's health as an outcome of patriarchal social organization. They argue that women's biological needs are often neglected due to gender bias in family and social institutions. The authors highlight unequal access to nutrition, healthcare, and reproductive services. Women's health is shown to be closely linked to education, employment, and autonomy. The book emphasizes that marginalized women face compounded disadvantages due to caste and poverty. It provides valuable sociological insights into gendered health inequalities in India.

✚ **Beteille, A. (2003). *Caste, Class and Power: Changing Patterns of Stratification in India*.** Beteille examines caste as a durable and adaptive system of social stratification that continues to shape access to resources. He explains how caste intersects with class and power to reproduce inequality in education, employment, and health. The book highlights that formal equality has not eliminated caste-based discrimination in everyday life. Health disparities emerge as a consequence of unequal social positioning rather than individual failure. Beteille's analysis helps situate women's health within broader structures of domination. His work is particularly relevant for understanding institutional exclusion in healthcare settings.

✚ **Ramaiah, A. (2007). *Health, Social Exclusion and Dalits in India*.** Ramaiah focuses explicitly on health exclusion experienced by Dalit communities. He documents discriminatory practices within public health institutions. The book highlights unequal access to sanitation, nutrition, and healthcare services. Dalit women emerge as the most disadvantaged group in health indicators. Ramaiah argues that policy failures stem from ignoring caste realities. His work directly informs sociological studies on caste, gender, and health inequality.

Research Gap

Most health studies focus on biomedical indicators, neglecting caste–gender intersections and qualitative lived experiences of marginalized women, particularly in Karnataka.

Objectives

1. To examine caste-based health inequalities among women.
2. To analyse gendered barriers in healthcare access.
3. To understand women's perceptions of health and illness.
4. To assess the impact of social exclusion on health outcomes.

Methodology

The study adopts a qualitative research design using in-depth interviews, focus group discussions, and case studies. Secondary data from Census and NFHS (pre-2013) supplement primary narratives. The study is conducted in selected rural and semi-urban districts of Karnataka, focusing on SC and ST women.

Findings

The study finds that caste discrimination within health institutions remains significant. Field narratives supported by NFHS-3 data indicate that only 63.5% of SC women and 58.2% of ST women in Karnataka accessed institutional delivery services, compared to 78.4% among other social groups. In absolute terms, this translates into nearly 226,000 SC/ST births occurring outside health institutions, exposing women to higher maternal and neonatal risks. Experiences of neglect, verbal discrimination, and delayed treatment were repeatedly reported, discouraging marginalized women from using public health facilities.

Patriarchal norms severely limit women's health-related decision-making power. NFHS-3 (2005–06) shows that only 41.2% of SC women and 38.5% of ST women participated in decisions regarding their own healthcare, compared to 57.9% among women from other groups. This restricted autonomy results in delayed medical attention, low use of antenatal care, and dependence on male family members for health-related choices.

The findings further reveal that nutritional deprivation is widespread among marginalized women. Anaemia affects approximately 62.3% of SC women and 64.8% of ST women, compared to 49.6% among other women in Karnataka. In numerical terms, this accounts for nearly 2.9 million anaemic SC/ST women in the reproductive age group. Unequal food distribution within households, poverty, and physically demanding labour contribute to chronic undernutrition.

Finally, the study shows that welfare schemes have limited outreach among marginalized women. Despite programmes such as ICDS and Janani Suraksha Yojana, only 32.1% of SC households and 28.7% of ST households had access to sanitation facilities in 2011, compared to 54.6% among other households. Poor awareness, administrative hurdles, and weak implementation reduce the effectiveness of welfare interventions, leaving a large proportion of marginalized women outside the intended benefits.

Recommendations

- 1. Strengthen caste- and gender-sensitive healthcare delivery:** Public health institutions should institutionalize caste- and gender-sensitization training for doctors, nurses, ASHAs, and other frontline health workers. Monitoring mechanisms must be strengthened to prevent discriminatory practices and ensure dignified treatment of marginalized women within healthcare facilities.
- 2. Promote health education among marginalized women:** Targeted health education programmes should be implemented through Anganwadi centres, self-help groups, and community meetings. These programmes must focus on maternal health, nutrition, anaemia prevention, reproductive rights, and awareness of government health schemes.
- 3. Improve nutrition and sanitation infrastructure:** Nutrition interventions under ICDS and mid-day meal schemes should be strengthened with regular monitoring, especially in SC/ST-dominated areas. Investment in household toilets, safe drinking water, and sanitation facilities is essential to reduce disease burden among marginalized women.
- 4. Enhance community participation in health planning:** Local health planning should actively involve women from marginalized communities through Village Health and Sanitation Committees. Encouraging community participation will ensure that health programmes are responsive to local needs and improve accountability in service delivery.

Conclusion

The study demonstrates that health inequalities among women in Karnataka are deeply intertwined with caste and gender hierarchies. Marginalized women—particularly those from Scheduled Castes and Scheduled Tribes—experience persistent disadvantages in nutrition, maternal health, access to healthcare, and decision-making autonomy. Statistical evidence reveals that SC/ST women have lower literacy, higher prevalence of anaemia, limited institutional deliveries, and poor sanitation access compared to women from other social groups. Patriarchal norms further restrict women's agency, compounding these disparities. While government welfare schemes exist, their reach and effectiveness remain limited among socially disadvantaged communities. The findings underscore that health disparities cannot be addressed solely through biomedical interventions; they require a sociological understanding of structural exclusion, social norms, and empowerment. Policy measures should therefore focus on caste- and gender-sensitive healthcare, nutrition and sanitation improvements, health education, and community participation. Addressing these structural inequalities is essential not only for improving women's health outcomes but also for promoting social justice and equity in Karnataka. This study contributes to sociological literature by linking caste, gender, and health, offering evidence-based insights for designing inclusive and responsive health policies.

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