ABSTRACT

ARTICULATION AND AGENCY IN WOMEN'S HEALTH: A STUDY IN RURAL KARNATAKA

Women's health status is closely associated with their social status; it reflects their self-worth and their social, economic and political value in the community to which they belong. It is a reflection of their empowerment or disempowerment in society. Therefore, a clear understanding of women's morbidities is critical. The literature review reveals that women encounter a range of morbidities. Rural women in particular report poor health outcomes. This range reported by women in general and by rural women in particular, is not necessarily acknowledged by planners. Policies and programmes tend to view women's health largely within the reproductive construct. This has implications for the redressal of women's health issues. If the state is acknowledging women's health needs in a limited manner, it becomes important to understand how do women themselves deal with the range of morbidities?

The aim of the study is to explore the varying forms of agency that different rural women engage in to address their health problems. This will throw light on local responses and will allow one to build on existing solutions and realities rather than only taking recourse to externally devised programmes and strategies.

The objectives are as follows:

1. To understand whether the key stratifiers (e.g., age, caste, class) result in different health outcomes for different categories of women
2. To assess whether a gap exists between the 'internal' (women's) and 'external'(health care providers') view regarding women's health
3. To assess whether there are different forms of agency exercised by different women
4. To understand whether women's agency in the health domain extends beyond health-seeking behaviour and whether and how this is influenced by the key stratifiers (e.g., age, caste, class)

The study was located in Boohalli village, Kankapura taluka, Ramanagaram district in Karnataka. This village was selected as an average representative village based on a range of variables. There are three major caste groups: Lingayaths, Gowdas (Vokkaligas) and Holeyas (Scheduled Castes - SCs). This community also includes so a few Other Backward Caste (OBC) members.

To meet the objectives, a mixed method approach was used with a qualitative dominant sequential. Insights and information procured from each preceding phase of data collection were used for the succeeding phase. In the first (qualitative) phase, data was collected from the women using participatory research (PR) methods. Key informant interviews were conducted with health care providers, Gram Panchayat officials, the school principal and self help group functionaries.

The second (quantitative) phase was executed through a survey. A 25 per cent sample of 118 women were interviewed. This was followed by the third (qualitative) phase where in-depth interviews were conducted with 15 women. This methodology yielded the following findings.

Dimensions of Morbidity

The health problems are divided into two basic categories: long and short term.

These problems arise both serially and simultaneously. During the 3-month recall period, the women reported a maximum of three long term and two short term health problems (5.9%). 28 per cent had at least one long and one short term problem. There is extensive co-morbidity among women in this village.

With regard to the long term health problems (LTHPs), there is a morbidity rate of 76.3 per cent. In short term health problems (STHPs), the morbidity rate is 88.14 per cent. With reference to the long term problems, there is a higher reporting from the older women, the higher castes, women from the upper class, widowed women and those carrying a heavy work burden. Regarding short term problems, there is higher reporting from the lower castes. There are no major variations based on age, class, marital status and work burden.

There is a vast range of both long and short term health problems. In LTHPs, there are differences based on age and caste. There are no major differences based on class. Marital status has no major bearing. A heavier work burden does translate into more fatigue-related health problems.

In STHPs, age is not a significant independent variable but caste appears to be. There are no major variations based on class, marital status or work burden.

The etiology of women's problems is primarily located in the deprived nutritional status combined with a heavy work burden and social responsibilities. Women also report some reasons which are not located in the bio-medical domain. This subjective view is sometimes at variance with the external view held by health care providers.

With reference to the duration, in the context of LTHPs, episodes usually last for 1-7 days. In the context of STHPs, all three categories of 1 day, 2-3 days and 4-7 days are almost equally represented. Women have been dealing with these problems recurrently for the last 30 years to three months.

Regarding duration of LTHPs, age, caste and class do not seem to have any bearing but marital status and number of occupations affects duration. Married and widowed women and those carrying a heavier work burden are unwell for longer periods.

In STHPs, the younger women, the SCs, high class group, widowed and married women and those carrying a heavy work burden report being unwell for a longer period.

To understand what is it that women do to address important health concerns, it is important to focus on problems articulated as serious. Of LTHPs, 29.5 per cent are reported as being serious. There is a higher incidence of serious conditions among older women, SCs and the higher class. Marital status and work burden are not seen exercising any major influence.

Of STHPs, 6.1 per cent are reported as serious. There is a higher reporting among younger women, SCs and women from the low class group. Marital status is

important as more married women reported serious STHPs. Work burden is not seen exercising any influence. Given this profile, what is it that women 'do' when they become unwell.

Women's Agency in the Context of Ill Health

Agency refers to the various acts that women engage in to reach self-proclaimed health goals. In the process of reaching these goals, they will encounter certain barriers. The manner in which they use different resources to overcome these barriers reflects their agency.

A useful starting point will be to assess to what extent are women able to reach these goals. As many as 10 out of 15 women stated that they are satisfied with reaching some measure of equilibrium: i.e., they become functional whether or not they are cured as they cannot afford extended periods of rest or heavy costs (associated perhaps with surgery). These findings refer to all the acts women engage in to reach these goals from the time the health problem was acknowledged.

In terms of the initial response, women who were successful in reaching health goals were primarily those who had the support of the immediate family.

With regard to the number of providers approached, some women saw as many as eight providers within a single episode indicating that women do 'shop' extensively. The study group of 118 women approached as many 61 providers with differing qualifications at locations as far away as 84 kms. reiterating that women tend to explore till they find an acceptable provider. Women's agency lies in their ability to strategise while seeking out the appropriate provider. For these women, what makes a provider acceptable is cost-beneficial treatment, good doctor-patient interface, being available, accessible and providing timely service.

These health problems cause considerable discomfort yet women are seen resting only in the very acute phase of the episode. They manage their problems through simple adjustments. Using a balm, sleeping on the floor, bringing in a relative to stay, modifying the style and volume of work are some examples. Their agency lies in these different acts.

The spouses are also seen carrying a disease burden but as a consequence there is quality health care sought out through heavy loans which is negligible in the case of the women. Despite this, women are seen spending on health care without extensive loans. The manner in which this money is secured reflects agency. These funds are usually obtained through the social network.

The social network is constructed from the immediate marital family, the extended marital family, the natal family and neighbours. The network acts as the biggest resource in countering multiple barriers that women deal with. There is a range of barriers but the predominant ones are poverty, poor access to quality care and a heavy work burden. The social network has a key role to play in extending support which is both emotional and practical (financial support, referrals, boarding/lodging and support in taking on roles assigned to the women).

The network has many features in terms of size, density and number of spans. Large networks are inevitably a great support as this means there is support from multiple sources. This study revealed that even when networks are small it is the nature of support that is more important. Dense networks where network members know each other are also useful. A large number of spans means that the people from different network sectors are familiar with each other. This implies that different people from different network sectors confer with each other and give the woman similar messages.

Some women are more effective in reaching their health goals than others. Those who are more successful are enabled by a social network. Women's agency lies in their ability to construct and take recourse to the network during episodes of ill health. Women who have failed to develop this network need to exercise their agency and develop these networks.

Different forms of agency are evident. These include oppositional agency (where women encountered resistance from the family in seeking health care), complicit agency (where the lead in securing health care was taken by a significant other) and agency of intention (where the woman herself takes the lead). Women express

different forms of agency depending on the nature of social support they obtain from the social network.

In conclusion, it is evident that the age, caste, class, work burden and marital status influence health outcomes though not always in a simple linear fashion. Women report a range of health outcomes so to reduce women's health to the reproductive domain is erroneous.

The role of some of the above mentioned variables is however not so clearly evident with regard to women's ability to exercise agency in negotiating episodes of ill health. Women of all age, caste, class, literacy status and head of household status groups are seen reaching their self-proclaimed health goals, i.e., effectively exercising agency. Instead, in this context, a key distinguishing factor is women's ability to generate and then use the social network to reach health goals. This establishes the importance of the social network as important source of support and an entry point in breaking the vicious cycle of ill health and poverty.