REVIEW OF RESEARCH
ISSN: 2249-894X
IMPACT FACTOR : 5.7631(UIF)
VOLUME - 14 | ISSUE - 7 | APRIL - 2025

THE INTERSECTIONS OF CASTE, CLASS, AND GENDER IN SHAPING HEALTH-SEEKING BEHAVIOR IN INDIA

Dr. Shabana Kesar
Associate Professor,
Department of Women Education, MANUU, Hyderabd.

ABSTRACT:

This paper explores how social stratifiers such as caste, class, and gender interact to influence health-seeking behavior in India. Drawing upon intersectionality as a theoretical framework, the paper examines structural inequalities that hinder access to healthcare for marginalized communities, especially Dalit and Adivasi women. Through case studies and existing research, the paper highlights the multi-layered barriers—economic, cultural, and institutional—that shape health outcomes and choices. It concludes with a set of policy recommendations aimed at creating a more inclusive and equitable health system.

KEYWORDS : *social stratifiers , theoretical framework , healthcare , marginalized communities.*

1. INTRODUCTION

Health-seeking behavior is a multifaceted process involving decisions and actions taken by individuals to achieve a state of physical, mental, or social well-being. These behaviors are influenced by a complex interplay of socio-economic, cultural, and political factors. In the Indian context, social stratification based on caste, class, and gender remains deeply entrenched and significantly shapes individual access to resources, including healthcare. Women, particularly those belonging to marginalized castes and lower economic classes, face intersecting forms of discrimination that restrict their ability to seek timely and appropriate medical help.

This paper argues that the intersections of caste, class, and gender cannot be understood in isolation but must be analyzed collectively to capture the nuanced ways in which health inequalities manifest. By utilizing an intersectional lens, this study seeks to illuminate the structural barriers that prevent marginalized populations from accessing healthcare and to propose pathways toward a more equitable healthcare system.

2. CONCEPTUAL FRAMEWORK

2.1 Intersectionality as a Lens

Intersectionality, a term coined by Kimberlé Crenshaw, provides a theoretical framework to analyze how various social identities such as caste, class, gender, ethnicity, and religion interact to produce unique experiences of oppression and privilege. In the context of health-seeking behavior, intersectionality allows us to understand why a Dalit woman may face more obstacles in accessing

healthcare compared to an upper-caste woman or a Dalit man. Her experiences are shaped not by one but multiple identities that collectively determine her social position and access to healthcare.

2.2 Health-Seeking Behavior Defined

Health-seeking behavior encompasses all activities undertaken by individuals who perceive themselves as having a health issue, with the goal of finding a remedy. These activities range from self-care and consultation with traditional healers to seeking treatment in formal healthcare settings. The decision-making process is shaped by several factors including awareness, availability of services, affordability, perceived quality of care, and socio-cultural norms. For marginalized populations, these factors are often further complicated by discriminatory practices and systemic neglect.

3. CASTE-BASED DISPARITIES IN HEALTHCARE ACCESS

3.1 Social Exclusion in Public Health Services

Caste-based discrimination continues to pervade India's healthcare system, manifesting in both overt and subtle forms. Dalits and Adivasis, historically oppressed and socially excluded, are often subjected to neglect and humiliation in public health institutions. Healthcare providers may show discriminatory attitudes—refusing to touch patients, assigning them last in queues, or exhibiting condescension and lack of empathy. In some rural hospitals, Dalit patients have reported being asked to clean their own beds or eat from separate utensils, echoing untouchability practices. These experiences foster a deep mistrust of the healthcare system among marginalized communities, discouraging them from accessing timely medical care.

3.2 Physical and Geographic Barriers

Marginalized caste groups often reside in segregated settlements—either on the fringes of villages or in geographically isolated tribal belts. This spatial marginalization leads to reduced access to healthcare infrastructure. Clinics and hospitals are frequently located in upper-caste dominant areas, making them socially and physically unwelcoming for Dalits and Adivasis. Poor roads, inadequate public transportation, and long distances further complicate emergency care, especially for women and children. In tribal areas, the absence of culturally sensitive health personnel and translators exacerbates the alienation, compelling communities to rely on traditional healers even for treatable conditions.

3.3 Caste, Knowledge, and Trust

Caste-based hierarchies also influence knowledge production and dissemination related to health. Dalit and tribal knowledge systems are often dismissed as 'unscientific' or inferior, undermining the legitimacy of their practices and eroding trust in external healthcare providers. Health campaigns, when designed without consulting these communities, fail to resonate and often result in poor uptake of services like vaccinations or maternal care. As a result, there is a significant gap between the healthcare system's offerings and the actual needs, beliefs, and experiences of these communities.

4. CLASS AND ECONOMIC CONSTRAINTS

4.1 Affordability and Out-of-Pocket Expenditure

Economic status plays a critical role in shaping health-seeking behavior. In India, out-of-pocket expenses account for a significant portion of total health expenditure, disproportionately affecting low-income families. These costs include consultation fees, diagnostics, medicines, and transport. For families living below the poverty line, even basic medical care can become unaffordable, pushing them into debt or forcing them to choose between health and other essentials like food and education.

4.2 Informal Work and Health Neglect

The informal sector employs a large share of the working poor, particularly women. With no job security, health insurance, or paid leave, these workers are compelled to ignore or delay medical treatment. A day spent at the hospital translates to a day's lost wages, making preventive care and early

diagnosis a luxury. The burden of household chores and care work, primarily shouldered by women, further reduces their time and opportunity to seek medical help.

5. GENDERED CONSTRAINTS IN HEALTH-SEEKING BEHAVIOR

5.1 Patriarchal Norms and Women's Autonomy

Patriarchal norms that prioritize men's health over women's are deeply ingrained in many Indian households. Women often need permission from male family members to visit a doctor. Even when ill, their needs may be considered secondary to those of children or male members. Limited mobility, lack of education, and dependency on male escorts further restrict women's access to healthcare facilities.

5.2 Stigma and Silence Around Reproductive Health

Reproductive and sexual health remains a stigmatized subject in many parts of India. Discussions around menstruation, contraception, sexually transmitted infections, or pregnancy complications are often silenced. This stigma leads to poor menstrual hygiene management, untreated gynecological infections, and high maternal mortality rates. Adolescent girls, in particular, suffer due to a lack of comprehensive sexual education and access to youth-friendly health services.

6. CASE STUDIES AND EMPIRICAL INSIGHTS

Case 1: Bihar – In public hospitals, Dalit women have reported being segregated during labor and delivery, subjected to verbal abuse, and denied pain relief. Such discriminatory practices discourage them from institutional deliveries.

Case 2: Chhattisgarh – Adivasi communities often avoid public healthcare due to language barriers, culturally inappropriate services, and the dismissive attitudes of medical staff. They prefer traditional healers who are accessible and respectful of their customs.

Case 3: Mumbai Slums – Women in urban informal settlements delay treatment because of overcrowded health centers, financial constraints, and domestic responsibilities. Many resort to over-the-counter drugs or local unlicensed practitioners.

These examples reflect the intersectional disadvantages faced by marginalized women across rural and urban settings, impacting both their physical and mental health.

7. INSTITUTIONAL GAPS AND POLICY RESPONSES

7.1 Limitations of Current Healthcare Policies

India's health policy architecture, though expansive in its ambitions, remains inadequately equipped to address the intersectional nature of health inequities. Programs like Janani Suraksha Yojana (JSY), Ayushman Bharat, and the National Health Mission (NHM) have increased access in certain regions but lack the nuance required to serve historically marginalized groups. Often, these policies focus on numerical targets and biomedical outcomes rather than addressing the root causes of exclusion such as caste bias, patriarchal norms, and poverty. Furthermore, systemic issues such as understaffed facilities, absenteeism, corruption, and lack of accountability mechanisms reduce the efficacy of service delivery.

7.2 Discrimination Within Healthcare Institutions

Marginalized patients—especially Dalit and Adivasi women—frequently report experiences of humiliation, neglect, and coercion in public health facilities. The absence of anti-discrimination training among health workers, combined with a lack of institutional grievance redressal mechanisms, creates a hostile environment for those already socially excluded. Caste-based discrimination often goes unrecorded and unpunished, normalizing unequal treatment and undermining trust in public institutions.

7.3 Lack of Disaggregated Data and Evidence-Based Policymaking

Policymaking is hindered by the absence of robust, disaggregated health data that reflect caste, class, and gender. This lack of visibility makes it difficult to identify specific needs or monitor disparities, rendering interventions blunt and ineffective. Without clear data, marginalized groups remain invisible in official statistics and policy planning, perpetuating their exclusion.

7.4 Towards Inclusive Policy Reform

An effective policy response must be rooted in an inclusive, rights-based framework that acknowledges the specific barriers faced by marginalized communities. This includes adopting intersectional analysis in program planning, consulting directly with affected communities, and ensuring that frontline health workers reflect the social diversity of the populations they serve. Institutional accountability, community monitoring, and participatory governance should form the backbone of any genuine reform process.

8. RECOMMENDATIONS

- **Curriculum Reform:** Incorporate modules on intersectionality and the social determinants of health into medical and public health education. This will help sensitize future healthcare professionals to the structural inequalities affecting patient care.
- **Infrastructure Development:** Increase investment in rural and tribal health infrastructure. Establish mobile health clinics, improve road connectivity, and deploy telemedicine units to bridge the urban-rural divide.
- **Community Health Workers:** Hire and train women from marginalized communities as Accredited Social Health Activists (ASHAs) to ensure cultural relevance and build community trust. Provide them with fair wages, regular training, and adequate support systems.
- **Culturally Sensitive Health Campaigns:** Develop public awareness campaigns that address stigma surrounding menstruation, sexual health, and maternal care. Use community media, local languages, and culturally resonant messages to ensure broader acceptance.
- **Data Transparency and Accountability:** Institutionalize the collection and public dissemination of health data disaggregated by caste, gender, and economic status. Use this data to monitor health disparities and tailor policy responses effectively.
- **Participatory Policy Design:** Involve marginalized groups in the design and evaluation of health programs. Engage with civil society organizations, women's collectives, and tribal councils to ensure policies are informed by lived realities.
- **Legal Safeguards and Institutional Accountability:** Introduce clear anti-discrimination policies within healthcare settings, backed by grievance redressal mechanisms and periodic audits. Encourage anonymous reporting and ensure punitive action against caste- and gender-based abuse.
- **Inclusive Representation:** Ensure representation of marginalized groups in decision-making bodies at all levels of the health system—from village health committees to national policy taskforces.

9. CONCLUSION

In a country as socially stratified as India, understanding health-seeking behavior through the combined lens of caste, class, and gender reveals the depth of existing healthcare inequities. Women at the intersections of these identities face unique vulnerabilities, often slipping through the cracks of the healthcare system. Their experiences challenge the myth of neutrality in healthcare and underscore the need for structural reforms.

Any effort to universalize healthcare in India must be rooted in the principles of equity rather than uniformity. A one-size-fits-all model fails to account for the layered disadvantages experienced by individuals at the intersections of caste, class, and gender. Recognizing health as a fundamental right

requires an intentional and inclusive approach that centers the lived realities of marginalized communities.

A transformative health policy must be both redistributive and recognitive. It must redistribute resources to underserved areas and populations while also recognizing and validating the identities, knowledge systems, and dignity of those historically excluded. Only through a sustained commitment to intersectional justice can India hope to realize the promise of health for all.

REFERENCES

1. Crenshaw, K. (1989). *Demarginalizing the Intersection of Race and Sex.*
2. George, A. (2007). Persistence of high maternal mortality in Koppal District, Karnataka: Observations from a community-based study.
3. Desai, S., & Dubey, A. (2011). *Caste in 21st Century India: Competing Narratives.*
4. Indian Journal of Gender Studies, various issues.
5. Ministry of Health and Family Welfare, Government of India (various reports).
6. Baru, R. (2015). *Healthcare Inequities in India: A Critique.*
7. Sen, G., Ostlin, P., & George, A. (2007). *Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it.*