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Defining Bodies, Health, and Work of Dalits: The Decisive Role of Caste in Kerala, India

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Abstract

Caste discrimination affects the health of Dalits beyond limited access to health services or wider determinants like education, employment, income, and housing. Kerala is a good example for this, despite social development changes in the state, caste still plays a significant psychological role in defining health and work for lower castes. However, psychological research often exhibited a strong conformity bias ending up in victim blaming by articulating lack of personal responsibility, ignoring Dalit efforts. Despite being labeled as apathetic, Dalits in Kerala have actively participated in employment, government programs, and public events, demonstrating their resistance and empowerment. The objective of this study is to investigate Dalit resistance efforts against being labeled as "less able-bodied" by upper caste and subsequent exclusion from daily wage labor.

A qualitative study was conducted among Dalits in a rural village in Kerala using case study method. The data collected were analyzed thematically using an inductive method and a phenomenological approach by allowing themes to emerge from the data and identifying patterns, similarities and differences.

The study findings indicate that Dalits strongly resist being labeled as "less able-bodied," which leads them to eschew labor. This resistance stems from their understanding of health as the absence of disease and functionality, and their resulting active maintenance of good health and active engagement in daily wage labour. For them absence of disease is the way to express availability for labor and being able to work without any difficulties is their way to express fitness for work.

Keywords

Health, Psychological pathways, Caste discrimination, Resistance

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Introduction

Advances in social determinants of health and health care have significantly improved the health status of people around the world (CSDH, WHO, 2008). While developments have improved overall health, Indigenous populations and marginalized caste groups often lag behind in health gains compared to other social groups. In India, this disparity is particularly evident, with Indigenous communities and lower castes constituting the social groups with the poorest health outcomes (Subramanian et al., 2006). Caste, a pervasive and oppressive social system prevalent worldwide, particularly in India, has a detrimental impact on the health of the lower caste (Thapa et al., 2021). Scholars have documented its detrimental impact on the health of lower caste individuals through different pathways including barriers to healthcare access and adverse social determinants of health (Ahmed & Mahapatro, 2023; R. Baru et al., 2010; R.V. Baru & Zafar, 2022; Johri & Anand, 2022).

Caste discrimination affects Dalit health beyond limited access to health services or wider determinants like education, employment, income, and housing. Kerala, a state in South India despite a relatively high level of social development even before independence, has still not able to produce any evidence to overcome the social exclusion and marginalization of lower castes. Studies and reports have consistently shown that lower castes in Kerala face increased disadvantages, including higher morbidity rates and limited access to healthcare services. When considering key indicators of population health and overall well-being, such as infant mortality rates, maternal mortality rates, and under-five mortality rates, lower caste communities in Kerala consistently lag behind other groups, with the exception of indigenous communities (Ministry of Tribal Affairs, 2013; Simon, 2007). The persistence of these disparities is a reminder that reformist measures of Kerala which improved the welfare of all made little improvement in the life and health of marginalized (Devika, 2010). The development strategy followed by the state is thus under question as to it's capability to achieve social equity and equality beyond enhancing the wellbeing of all.

Evidence from around the world shows that the body assumes a pivotal role in the subalternization processes. Practices involving clothing and body modification have played a significant role in the subalternization processes during European colonization in Africa (Martí, 2012). Within the context of colonialism in India, medicine emerges as one among numerous tools employed for the purposes of colonization, racialization, stigmatization, and the marginalization of indigenous populations (Arnold, 1993). Even though colonization lost its power in India, caste based discrimination still exists and it became stronger in the marginalization of lower castes by defining and labeling their bodies and health. The fear that providing modern education to the children of lower caste communities would lead to a labor shortage in the fields was prevalent among the upper castes in the state (Kali, 2000).

The existing literature reveals a lack of significant efforts to enhance the skills and capabilities of Dalit workers in response to evolving labor market demands. Kerala's most marginalized Dalit communities possessed valuable agricultural capacities,

particularly in rice farming. However, the state never recognized these capabilities as potential assets that could be further developed and transformed into comprehensive capabilities (Devika, 2010). Despite implementing general welfare measures in Kerala that improved the population's overall well-being, little progress was made in terms of skill development among Dalits. For instance, the land reforms of the 1970s primarily provided homestead lands to landless laborers, which improved their living conditions but failed to nurture their existing inclination towards agriculture into fully-fledged capabilities (Devika, 2010). Hence the government through its welfare measures instead of substantial expansion of the access of Dalit labourers to what is now recognized as basic capabilities, devalued and ignored the possibilities of their existing dispositions and skills and left them free in an unfamiliar competitive labour market to be labeled by the dominant forces.

Dalit resistance against caste-based discrimination in local temples remains prevalent in Kerala, with numerous successful examples of Dalit resistance.[1] Political and civil society organizations of Dalits focus on land rights, education, health, and have brought positive changes to the lives of many Dalits in the state. Dalits have resisted displacement for developmental projects including land acquisition for big projects, as well as protests against minor projects at the village level.[2] Such resistances are prominent when we understand the fact that collective action of Dalits faced hostility in the state from different spheres of public life in the state (Bhaskaran, 2011). To know how Dalits deal with such hostilities and how they overcome the generalizing notions of universal victimhood, it is important to locate narratives of Dalit daily life, agency, and resistance in the wider collective Dalit resistance. Hence it would be interesting to know resistance towards labeling Dalit as less able bodied and keeping them away from daily wage labour in the context of wider Dalit resistance in the region and state.

Methodology

The study investigates Dalit resistance efforts against being labeled as "less able-bodied" and subsequent exclusion from daily wage labor by other social groups. The study used a qualitative case study design to explore the labeling of Dalit resistance efforts against being labeled as "less able-bodied" by the upper caste and subsequent exclusion from daily wage labor. The data collection for the study was conducted

[1]There are recent and old examples of successful Dalit resistance against not being allowed to enter the temple or perform any religious rituals. In January 2018, Dalits of Vadayampady, Ernakulam district, tore down a caste wall erected by the upper-caste Hindus to keep Dalits from going near the Bhajana Madam Devi Temple (T. A. Ameerudheen, 2018). In November 2021, Dalits entered the 'Jatadhari Devasthanam,' a temple in Swarga, Enmakaje Panchayat, Kasargod, Kerala, and climbed 18 steps. In doing so, they effectively declared an end to the age-old custom that had prevailed in the village (T. Ameerudheen, 2021).

[2]Examples of such resistances range from resistance against land acquisition for big projects like Cochin International Airport Limited during the early 1990s and protests against minor projects at the village level, like the protest against the construction of a waste treatment plant in Keezhattoor village in 2018.

from March to August 2021 in a village, Pozhuthana in Wayanad district and Malabar region of Kerala. Since the study was about labeling Dalits and their resistance, the village was selected based on the presence of Dalits and other social groups. During 2011, the village has a population of 18,404 individuals residing in 4,255 households. In 2015, the religious composition of the village was 37.06 per cent Muslim, 22.82 per cent Hindu, 17.72 per cent Scheduled Tribes, 5.75 per cent Christian, and 6.62 per cent Scheduled Caste (Dalit).

Data Collection and Sampling

The study employed a purposive sampling technique to select samples that could provide the best information to obtain the study objectives after getting familiarized with the field through a previous survey. The sample size for the study was determined by following the principle of saturation in the process of data collection. The goal was to have a large enough sample size to sufficiently answer the research objectives while not giving repetitive data without any additional perspective or information. Data collection involved fifteen in-depth interviews, four group discussions, and eight key informant interviews with academicians, local health workers, local politicians, and members of worker's unions. Continuous data analysis (data coding and initial theme building) was carried out during the data collection. After the twelfth interview, the initial analysis did not result in obtaining any additional perspectives or information without giving repetitive data. Hence, the researcher concluded the data collection after the fifteenth in-depth interview, ensuring that saturation of themes was achieved.

Data Analysis

To gain a deep understanding of Dalit experiences, perspectives, and resistance against being labeled less able-bodied, the study employed thematic analysis with an inductive and phenomenological approach. Themes were allowed to emerge directly from the data itself, rather than imposing predetermined categories. The study focused on capturing the lived experiences and perspectives of Dalit participants. The data analysis involved a multi-step process: first, transcripts were reread extensively to grasp the participants' experiences and viewpoints in their totality. Second, key portions of the data containing important insights were pinpointed, and third, these segments were assigned codes that captured their core content. In the fourth step, codes were grouped into broader categories based on similarities and differences, forming potential themes. In the fifth step, initial themes were refined and finalized, and clear names were given for further analysis. This approach ensured a data-driven exploration, delving into Dalits' lived experiences and resistance strategies against the imposed label.

Ethical Consideration

This study did not involve any medical interventions and posed no potential risks to participants. Informed verbal consent was obtained from all respondents after providing sufficient information about the study, including the voluntary nature of

participation and the absence of direct risks or benefits. To protect confidentiality, information that could identify respondents is anonymized in the study report. There are no potential conflicts of interest for the author in presenting the results or at any stage of this research work.

Results

Both caste-oriented labeling of Dalit daily wage laborers as less able-bodied or less skilled by other communities and resistance from Dalits towards such labeling are routed in caste-related cognition, emotion, and behavior of Dalits and Upper caste. This necessitates psychological exploration of caste-based labeling of Dalits and Dalit's resistance towards such labeling. At the same time, it is important to place the exploration in the wider socioeconomic and cultural life histories of Dalits and other communities. In this backdrop of wider Dalit resistance happening in the region and state, the results of the study are presented by reporting the major themes and subthemes that evolved about the labeling of Dalits, the occupational challenges they face, and their idea of health, and by presenting the perspectives of the different stakeholders who participated in this study. The themes and subthemes that emerged from the data, along with some responses from respondents recorded by in-depth interviews, are presented in Table 1.

Table 1: The responses of respondents recorded by in-depth interviews

Theme	Subtheme	Respondent	Respondents comments
Making sense of health	Definition of health	Dalit man, 50-year-old	*Being able to do day-to-day activities of life and having no major diseases……*
	Self-responsibility	Dalit daily wage labour	*…when we heard about people facing dizziness and fainting after taking tablets for 'elipani' (leptospirosis), we were a little reluctant to take it…but after the health inspector told us why the dizziness was happening and that it could be avoided if it was taken after a meal or snack, we all took the medicine.*
	Acute and chronic susceptibility	Dalit man, plantation worker	*After the work of spraying pesticide, I will not be able to do anything. Usually, I go lie down on the verandah for some time to get relief from fatigue. Not just the present health issues from it, these are heavy pesticides and will have serious health consequences in the future.*
Labeling	Lack of hygiene	retired government servant	*…use of river water for household use will create health problems….this is one of the reasons for continuous health problems among Adivasis and Dalits living on the river banks.*
	Health damaging behavior	local politician	*…there are good changes. But still they don't see whether family is hungry or not, they drink whatever they want with the days wage…*
	Reluctant to change	local health workers	*…even though we tell them many times, they will not turn up to get treatment immediately after a health issue. They will do lot of home remedies and will turn up to the PHC only when the disease is versioned…...*
	Lack of collective efforts	Local politician and member of community based palliative	*…..very few among them participate in such programmes…. it is not just about whether they have money or not, it's about whether they have commitment towards the society or not….. not just in health, in other collective efforts of the community too they turn up in less number…..*

Occupational challenges	Physical and skill demands	Upper caste Hindu men	*….they have better health, hence perform better in work also…..Bengalis (migrant daily wage labours from north India) are very fast.They do any job without any difficulty….they carry heavy load in head to second and third floor quickly….it is not possible for local daily wage labours….*
	Quality of work	Muslim men	*……. beauty is not important for them.When we do any work we think about many designs and the most trending or a variety one will be used…you look at their houses. They will not give much importance to beauty of building.*
	Availability and ability for work	Dalit men, plantation worker	……Always it is not possible to deny work. Sometimes I go for work with health issues….in a month, getting 10 or 15 days work is lucky. It is not possible to deny it by pointing health issues…..if it is too difficult to manage, then only I skip the work……

Labeling of Dalit Bodies, Behavior and Social Life

In the village, Dalits face the burden of labels and stereotypes associated with their caste, which significantly contribute to their health-related challenges. First, local health workers, including health inspectors and doctors, hold a perception that Dalits lack hygiene and reside in unhygienic environments. The observations leading to such a perception among health workers include inadequate sanitation facilities, improper garbage disposal, and a lack of clean water sources in Dalit colonies, which can contribute to the spread of diseases and health issues among Dalits. Moreover, villagers from other social groups also adopt the same observations made by local health workers, extending them beyond the living environment to Dalits' bodies and behaviors. They view Dalits as practicing poor personal hygiene, such as bathing in polluted water, inadequate hand washing, oral hygiene, and wearing unclean clothing.

These practices, which are essential for maintaining good health according to the villagers, reinforce negative stereotypes about Dalit hygiene and living conditions, leading to discrimination and exclusion. The real-world consequences of such stereotypes are particularly pronounced for Dalits. Even today, not visibly widespread as it exists earlier, individuals from other castes, such as Brahmins, Nayar, and Thiyya, particularly older members of these castes, refrain from eating food from Dalit households due to concerns about hygiene and purity.

The lack of access to clean household water compels Dalits to heavily rely on river water. However, upper-caste individuals consider this practice unhygienic and detrimental to health, despite it being the only available water source for many. Affluent households, especially upper-caste Hindus, believe that using river water for domestic purposes poses health hazards. One retired upper-caste Hindu government servant said,

> *The river water is highly polluted due to chemical spraying in coffee plantations. During rainfall, the chemicals sprayed on the plantations flow into the river. Additionally, waste is dumped into the river. The use of river*

> *water for household purposes will lead to health problems. This is one of the reasons for the ongoing health issues among Adivasis and Dalits living along the riverbanks.*

Consequently, the usage of river water by Dalits for household needs is stigmatized as an unhygienic practice, further perpetuating negative perceptions about their hygiene, living conditions and overall health status

Dalit workers in the village are often labeled, with claims that their poor hygiene practices contribute to high and persistent health issues. As a result, their physical health is compromised, affecting their efficiency in daily wage labor. In essence, these labelers attribute the lack of hygienic behavior as the primary cause of the high morbidity and resulting physical weakness among Dalits. Additionally, studies conducted in the region have consistently observed higher levels of morbidity among scheduled castes and scheduled tribes compared to their counterparts. However, it is important to note that the main factors contributing to increased morbidity rates among Dalits are attributed to poor socioeconomic conditions (Navaneethan & Kabir, 2009; Krishnan, 2009), which are themselves shaped by inter-caste disparities (Deshpande, 2000).

Second, health-damaging behavior, such as the use of alcohol and tobacco products, is seen as an example of a lack of self-responsibility among Dalits, which is yet another form of labeling. Both members of local political parties and local health services along with higher caste Hindus and Muslims opined that Dalit men from the village consume alcohol at hazardous levels compared to men from other social groups except Adivasis. Further it is opined that alcohol consumption is linked to the cultural practices of Dalits and they neglect the acute and chronic impact of alcoholism on health. A Muslim shopkeeper said,

> *...father and children drink. That is not a problem for them. . .they are not at all worried about the long-term health issues of drinking. If they have worries, they would have kept their children away from all this.*

Additionally, the higher spending on alcohol and tobacco products when the family still falls in the trap of hunger is considered a lack of responsibility towards family. A local politician in the village said,

> *…there are good changes. But still they don't see whether family is in hunger or not, they drink whatever they want with the day's wage…*

Instead of viewing alcohol addiction among Dalits as a social problem, it has been understood as a behavioural problem and in turn Dalits are labeled as someone who lacks self-control and responsibility towards health and family.

Third, there is a perception among local health workers, politicians, and upper-caste members that Dalits are reluctant to change, which is seen as an innate trait. One upper-caste Hindu man who employs Dalits on his agricultural land believes that

untreated health issues and the consequent exacerbation of existing health conditions are common among Dalit families. Local health workers share a similar opinion, believing that delaying treatment for even communicable diseases is common among Dalit families, leading to the spread of such diseases to all family members if one member is affected. One of the local health workers said,

> *Even though we tell them many times, they will not turn up to get treatment immediately after a health issue. They will do lot of home remedies and will turn up to the PHC only when the disease is worsened.*

Such labeling is done without understanding the health-seeking behavior of Dalits in their socioeconomic context and their practice of self-treatment and local health traditions. Evidence shows that home remedies among Dalits are routed in their local health tradition and their conceptualization of health and illness (Nandu, 2021). Further, it is identified that viewing Local Health Tradition as one of the bases to build upon for a continuation of care, from home and community, to health centres and dispensaries, to hospitals will serve the people best (Saxena & Priya, 2009).

Members of local political parties and health services have pointed to several examples of what they see as Dalits' reluctance to change. These include continued addiction to alcohol even after efforts from various sources to sensitize the community, high rates of student dropout in Grades 9 and 12, and a lack of effort to clean their surroundings to prevent vector-borne diseases during the monsoon season. This labeling reinforces stereotypes about Dalits and ignores the fact that change is often difficult and requires systemic interventions that address the underlying socioeconomic and cultural factors. There are some superficial shreds of evidence to support the arguments of labelers, but it is crucial to consider the context in which these behaviors occur. For example, the high rates of student dropout among Dalits are due to a number of factors, including economic hardship and social discrimination; prevalence of alcohol addiction is not a moral failing but induced by structural factors including poverty and economic hardship, social exclusion, discrimination and cultural factors; their living environment is less hygienic because they are forced to live in congested caste colonies (Pramod, 2020).

Finally, local politicians and health workers believe that there is a lack of collective effort from the Dalit community in improving the health of the community as whole, which is another form of labeling that places blame on the community. They cite the lack of large-scale Dalit participation in community-led initiatives for health, such as community-based palliative care services and treatment relief committees[3] in the village, as evidence of this. One member of the local political party and an active member of community palliative services said,

[3]The treatment relief committees are local informal forum of villagers that formed to provide assistance, support, and relief to poor individuals facing sudden health related challenges. Such committees involved in a wide range of activities such as facilitating medical aid, distributing food and supplies, and offering financial assistance.

> *Very few among them participate in such programmes…. it is not just about whether they have money or not, it's about whether they have commitment towards the society or not … not just in health, in other collective efforts of the community too they turn up in less number…..*

Even though Dalits participate in such committees and programmes, compared to other communities their participation is lower. The social networks of Dalits that facilitate their involvement in public activities of the village are limited by discriminatory practices towards Dalits and their weak economic, social, and political position (Nandu, 2021). Similarly, at the household level, missing medical help during the time of need is seen as lack of responsibility without addressing the lack of resources leading to missed healthcare. When we understand the accumulation of unmet health needs among Dalits in the village in relation to what is happening outside, we will understand that missing medical care among Dalits is not because they lack responsibility or just because they wanted to wait and see if problem improved without medical attention. The major reasons for unmet needs for health care utilization include non-affordability due to expensive health care, inability to manage time because of work, care for children or for others, lack of transportation leading to barriers in traveling long distances, fear of health professionals, health organizations and treatment procedures, and lack of knowledge about good health workers and institutions (WHO, n.d.).

Marginalization of Dalit Labours

The labeling of Dalits as frail and less able bodied has contributed to the marginalization of Dalit laborers in the village, resulting in various occupational challenges. These challenges form the second theme, which is influenced by the occupational practices among Dalits. This theme encompasses factors that affect their occupational status and their ability to resist attacks on these practices. It is further divided into three sub-themes: physical and skill demands for work, quality of work, and the availability and ability to work.

First, the theme of occupational challenges is shaped by the sub-theme of physical and skill demands for work. Hard physical work is inherent in their traditional occupation as agricultural laborers. However, with a major shift in agriculture from food crops to cash crops, the majority of Dalits have become daily wage laborers in plantations and other sectors such as construction. This shift has occurred without any improvement in the capabilities of Dalit agricultural workers. Now they find themselves in a new sector or on plantations as daily wage laborers, competing with daily wage laborers from other communities who are already engaged in such work. This shift has led to a mismatch between the skills possessed by Dalit workers and the skill requirements of different sectors, as well as the skills possessed by other daily wage labours.

Dalits possess exceptional skills in agriculture, such as farming techniques, knowledge of weather conditions, the natural cycle of plants and animals, and soil and water management, to make cultivation highly productive. However, when they enter the field of daily wage labor outside of agriculture, these skills are not utilized, and they lack many of the skills required for the new work, such as masonry, measuring, cleaning, quality maintenance, equipment operation, problem-solving, and time management. This skill mismatch has resulted in a decrease in the amount of work done by Dalit workers compared to others. Unfortunately, this aspect is often overlooked, and the poor performance of Dalit laborers in terms of 'work quantity' is attributed solely to their lack of physical strength and poor health. The work of Dalit daily wage laborers is frequently compared to that of migrant workers from northern India, as they are increasingly replacing unskilled Dalit laborers in the village. One upper-caste Hindu villager said,

> *They have better health, hence perform better in work also. Bengalis (migrant daily wage labours from north India) are very fast. They do any job without any difficulty….they carry heavy load on their head to the second and third floors quickly….it is not possible for local daily wage labours….*

The physical fitness and dietary habits of migrant laborers are considered crucial factors by the villagers, as they believe these attributes contribute to the higher speed and quantity of work performed by migrant laborers. Many in Kerala prefer migrant laborers over local daily wage laborers due to several factors, as noted by Peter and Gupta (2020). Migrants are often single, which makes their employment more convenient. They are also perceived as being less expensive, more subservient, hardworking, and available throughout the year. Consequently, in various fields that involve physically demanding work, migrant workers are extensively employed in comparison to native laborers (Peter & Narendran, 2017).

The second sub-theme focuses on the quantity and quality of work, as evidenced by codes such as "quality of work." These codes shed light on the challenges encountered by Dalit workers in meeting work requirements and achieving satisfactory results. The villagers differentiated the quality and quantity of work performed by Dalit workers, often perceiving it as lower compared to other communities. This distinction is frequently based on aesthetics and the level of precision observed in construction projects completed by individuals from various backgrounds. For instance, a Muslim resident of the village employed a Dalit mason to construct a boundary wall for his house, said as follows,

> *They won't be able to do such works in perfection…the strength of the wall and beauty in appearance both is important in perfection…strength will be there in their work, but they cannot always ensure that perfection…..*

The villagers identified this 'lack of perfection' in the personal shortcomings of Dalit individuals and in their cultural practices as a community. A mason belonging to the Thiyya community mentioned that,

> *…beauty is not important for them. When we do any work we think about many designs and the most trending or a variety one will be used…you look at their houses. They will not give much importance to beauty of building.*

To such arguments, the response provided by a Dalit mason in the village was intriguing. He said,

> *…..I do consider beauty. But some of the designs using for beauty will compromise the strength of the building. Hence I do not try such designs and if someone is asking to do, I politely withdraw from the work…..if they are insisting sometimes I do such works in owners responsibility.*

His words indicate that, to him, the physical strength of a building or structure holds greater significance than its architectural beauty. In the village, Dalits primarily rely on traditional, locally tested knowledge and construction practices that have been passed down through generations. Unlike other daily wage laborers, they have limited exposure to new technologies and construction skills, which are familiar to laborers who have strong social networks enabling them to stay connected with latest designs and technologies.

The third sub-theme that shapes the theme of occupational challenges is "Availability and Ability for Work." This sub-theme includes codes such as "expressing availability for work" and "able body for work," which emphasize the importance of physical fitness and availability for work. The availability of work poses a significant problem for Dalits, as they only receive 10 to 20 days of daily wage work per month, which is insufficient to meet even the basic needs of their families. Several factors contribute to the limited number of work days. These include a shift towards cash crops resulting in a shortage of agricultural work, a lack of occupational diversification among Dalits, inadequate skills or experience in handling machinery for construction work, and intense competition with daily wage workers from other communities and migrant labours. In fact, there is a preference for migrant workers from North India in many daily wage jobs that Dalits used to perform in the village. The reason cited for this preference is that migrant laborers can complete more work in a day.

Regarding the ability to work, certain types of work themselves contribute to poor health. Despite being aware of the health issues associated with specific daily wage labor, Dalits continue to engage in such work due to the un-affordability of taking time off. Experiencing hunger is not an uncommon thing among poor Dalits in the village, and a loss of wages for even a few days would lead to several days of hunger for their families. To add one more dimension to this, a Dalit daily wage labour, Kumaran said that,

> *Not doing work means you are not healthy…those who are simply wasting time by not doing any work means he is physically or mentally not fit.*

For him not working implies poor health and being physically or mentally unfit. The central part of the respondent's conceptualization of good health is the ability to function normally. Being incapacitated to do work is considered a sign of bad health. However, the decision to be incapacitated is not solely based on physical and biological factors, but is often influenced by various pressures. He opined that it is not affordable for him to deny all the work days he gets by showing his incapacity to do the work. Instead, he hides his incapacity or manages it through self-treatment to express his fitness for work and ensure that the work is done without any disturbance. Even though physically incapacitated from doing work, not going for work that is available after several days of joblessness is not affordable for Dalits who are daily wage laborers in the village. Kumaran also said,

> *Always it is not possible to deny work. Sometimes I go for work with health issues….in a month, getting 10 or 15 days work is lucky. It is not possible to deny it by pointing health issues. If it is too difficult to manage, then only I skip the work.*

Even though he is aware of his inability to work due to health issues, not having that job would pose even greater difficulties for his life and family. Therefore, by successfully completing the work, he demonstrates that his body possesses enough capacity to perform the work.

Shaping of Resistance from Health and Healthcare as Utilization

The theme of making sense of health among Dalits in this study is shaped by three subthemes. The first subtheme is the definition of health. What does health mean to a comparatively poor Dalit living in the rural village of Kerala? *'Being able to do day-to-day activities of life and having no major diseases...'* was the response of a 50-year-old Dalit man who works as daily wage labor in the village. Whether or not such perceptions are valid or have the endorsement of the scientific community is open to question, but at any rate, such an understanding appears to be an inevitable result of their living conditions. In their definition, the focus is on the physical strength of an individual human being, with functional activity and the absence of major diseases. The physical strength of an individual and functional activity is expressed through their work, which is daily wage labor.

Further, the second part of their definition is about major diseases. A major disease is understood as any health issue that incapacitates work or day-to-day activities. In their definition, health can be with or without any mild illness or disease, as long as one retains the necessary ability to perform the functions they wish and need to perform they are healthy. So, what saves one from bad health? For them, it is through

minimizing the risk of being incapacitated and ensuring strength to the body through having enough to eat. What is central to their view is the work-food-health relationship, and that is an important articulation among Dalits in the village, especially those who are comparatively poor.

The next subtheme that shapes the theme of "making sense of health" is "self-responsibility." This subtheme refutes the argument that Dalits are least concerned about their health. Instead, it shows that Dalits recognize the importance of self-responsibility for good health and do not neglect it. This argument is made even though Dalits acknowledge that health-damaging behaviors such as alcohol addiction and tobacco use are more prevalent among them than in other social groups. These two observations are not contradictory. One can see that they acknowledge health-damaging behaviors as a psychosocial problem and point out that they are caused by various socioeconomic and cultural factors that go beyond their conceptualization of good health.

Furthermore, Dalits in the village exhibit a strong understanding of individual and collective responsibility, evident in their concerns about local disease outbreaks and their perception of their bodies being highly vulnerable to such outbreaks. For instance, they engaged in preventive measures such as taking prophylaxis for leptospirosis following a severe flood in 2019. They also practiced preventive measures like social distancing, using soaps and sanitizers during the COVID-19 pandemic, and implement vector control measures at the household level to prevent dengue outbreaks during monsoon seasons. A Dalit housewife, who serves as the secretary of a self-help group in the village mentioned as follows,

> *When we heard about people facing dizziness and faintness after taking tablets for 'elipani' (leptospirosis), we were little reluctant to take it. But after the health inspector told us why dizziness is happening and it can be avoided if it is taken after a meal or snack, we all took the medicine.*

Her words show that despite initial skepticism in the village regarding the use of doxycycline tablets for leptospirosis prophylaxis, Dalits in the community decided to undergo this preventive measure. They recognized the potential risk of exposure during floods and understood the importance of prophylaxis. This serves as a significant example of their awareness of the susceptibility of their bodies to local disease outbreaks and emphasizes the significance of individual and collective responsibility in preventing such outbreaks.

Coming to the acute and chronic susceptibility to disease, a Dalit man employed in the tea plantation said,

> *After the work of spraying pesticide, I will not be able to do anything. Usually, I go and lie down in the verandah for some time to get relief from fatigue. Not just the present health issues from it, these are heavy pesticides and will have serious health consequences in the future.*

His words demonstrate their belief in the susceptibility to both acute and chronic diseases, which they perceive as capable of accumulating and resulting in negative health consequences. They are also well aware of the detrimental effects of acute health issues associated with employment, and they emphasize the importance of rest and leisure in alleviating work-related fatigue. Moreover, Dalits are aware of the potential health risks if they do not take steps to enhance their quality of life.

Discussion

Analysis of the data shows that there is caste-oriented labeling of Dalit daily wage labours as less able-bodied by other communities, and there are counter-narratives or resistance from among the Dalits towards such labeling. Both the labeling and resistance are routed in the day-to-day life activities related to the work and health of Dalits and others in the village. Labeling includes lacking hygiene, following health damaging behavior, reluctant to change, and lacking collective efforts leading to occupational challenges among the Dalits. These challenges are mainly in the areas of physical and skill demand, quality of work done, and availability and ability to work. In other words, labeling Dalits as less able bodied is leading to occupational challenges among the Dalit daily wage labourers. Dalits strongly resist being labeled as "less able-bodied," which eschew them from labor. This resistance of Dalits stems from their understanding of health as functionality and the absence of disease, and their resulting active maintenance of good health and active engagement in daily wage labour. For them absence of disease is the way to express availability for labor and being able to work without any difficulties is their way to express fitness for work.

As elsewhere, the rigid connection between being lower caste and from a lower social class leading to social psychological repercussions among Dalits, such as humiliation exists in the state of Kerala and study region. At the same time, evidences shows that the intensity of such repercussions can be diluted through the realization of self-worth in the form of collective pride and dignity (Sinha, 2020). Further, it could be understood that the everyday acts of subaltern negotiation involve acts of resistance in the face of hegemonic power structures (Chandra, 2015). This study shows that Dalit's lives in the village are not only shaped by their marginality but are also shaped by their agency, resistance, and power, which they practice in their daily life. As shown in the data, actively engaging in daily wage labour at the time of availability and performing the work at maximum perfection even during health issues is an example of resistance against being labeled as apathetic. The interventions of early Dalit leaders, especially the prominent Pulaya leader Ayyan Kali, in Travancore provide enough evidence to believe that very early itself representatives of people who actually worked on the land did value their existing dispositions and skills, and were eager to respond to emerging market opportunities through developing these into capacities and conjoining them with abilities (Devika, 2010). However, the present study shows that even though Dalits are eager, labeling them as apathetic reduces their chances of improving their skills in the day-to-day life.

In Kerala, through the institutionalized martial culture and the *chekavan* tradition, the Nayar and Thiyya community which are above the Dalits in caste hierarchy maintained a 'strong body' image and consequent view of health as a continuum of fitness (Nandu, 2021). Over the long period of casteism-linked martial arts, the accumulation of knowledge about the physical strength of the body contributed to the political and ideological articulation of caste-centric strength of the body. Thus, the human body cannot be regarded as merely a matter of biological interest. Such an understanding of health by dominant castes labeled Dalits and Adivasis as of poor health, especially of poor physical strength. Dalit workers in the village are labeled as having high and persisting health issues due to poor hygiene practices and behavioural issues, hence having compromised physical health and efficiency in daily wage labour. Even though it is true that Dalits and Adivasis in the region and state have higher morbidity compared to other social groups, the reasons are not attributed to behavioral issues. Higher morbidity rates among Dalits are attributed to poor socioeconomic factors (Navaneethan & Kabir, 2009; Krishnan, 2009) influenced by inter-caste disparities (Deshpande, 2000). Other than anyone else, Dalits from the village understand this fact that it is structural factors and caste discrimination which limits their chances of improving health and work. Hence they resist labeling by articulating their points in the public spheres available to them like expressing Dalit views on alcohol addiction in the village level meetings, SHG meetings and at the work sites.

The public opinion among Dalits in the village no longer looks upon the excessive drinker as one who lacks will power or is worthless. Instead, they consider those who are alcoholic are not just alcoholic, and fulfill their familial and social responsibility in the form of going for regular works at the time of availability, looking after family matters, getting married, having offspring and leading life. Further they cite success stories of de-addiction treatment by showing examples of those who are alcohol addicted got treated and rehabilitated in their village. Hence the labeling of excessive drinkers among Dalits as worthless and following health damaging behavior is resisted by the Dalits through their developing informed public opinion on alcohol addiction. They understand that alcoholism is a form of illness, and that with proper medical and psychiatric treatment it can be treated. The developing informed public opinion no longer looks upon the excessive drinker as one who lacks will power, has sinned, or is worthless. Instead, an increasing number of people are coming to realize that alcoholism is a form of illness, and that with proper medical and psychiatric facilities rehabilitation can be achieved (Straus, 1950). When such structural and social determinants of health are the reasons for high morbidity, blaming the behavior of the affected is the easiest and most common way to criticize them.

The burden of labels and stereotypes constitutes representational violence and everyday suffering, both of which are associated with the condition of subordinated caste identity and the caste subordination of Dalits. The social life of ex-slave castes or ex-untouchable caste identities is, in fact, functioning structurally as a social fact, which significantly contributes to Dalits' everyday life, including their health-related challenges. The historicity of the Dalit untouchable body and the cultural

symbolic attribution of their body as an object of untouchability also functions as representational violence. The portrayal of a 'less-abled' body can be seen as structural violence, contributing to the everyday suffering of Dalits in their contemporary lives.

The findings of the study show that the representation of the Dalit body as an object of social untouchability, reinforced by negative stereotypes about their hygiene and living conditions, contributes to social discrimination and everyday exclusion. The notion of caste purity related to untouchability and the bodily hexis of dominance and subordination are constitutive factors of cultural habitus, as well as the notional and institutional dispositions of caste hierarchy, which reproduce social prejudices regarding community hygiene and public purity. The availability of common resources, including water—for example, the use of river water by Dalits for household needs—is also stigmatized as an unhygienic practice. Dalit workers in the village are labeled as bodies of poor hygiene, an enduring representational vestige of impurity, which is culturally equated with Brahmanic notions of impurity and the unhygienic practices associated with the dominant practice of untouchability.

The importance of this study is that the labels, attributions, and representations of Dalits by other social groups reinforce social dominance. Dalits are stigmatized as lacking hygienic behavior, which is negatively attributed as the primary cause of their high morbidity and physical weakness. The Dalit body is represented as inherently unhygienic and less able. This caste-based prejudice reflects a 'caste of mind' mentality held by the general public, without considering the material conditions and structural factors at play in social power relations. It also overlooks the everyday living conditions of Dalits in particular, and the broader functioning of caste society in general. Caste prejudice and caste discrimination are important factors that influence the social common sense and public sensibility, treating Dalits as a less able-bodied community on the one hand, and shaping views on public health, notions of disease, and labor activities on the other.

The study is also important in concluding that Dalits are actively resisting caste discrimination and working to improve their health and well-being. This is an important reminder that Dalits are not passive victims of discrimination, but rather active agents of change. It is important to recognize that caste discrimination is a major determinant of health and work for Dalits. Welfare measures including interventions in public health and employment should be designed to empower Dalits and help them resist caste discrimination.

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