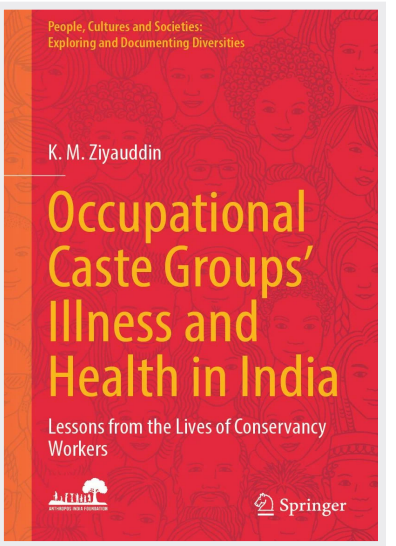
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Occupational Caste Groups' Illness and Health in India

Lessons from the Lives of Conservancy Workers



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K.M. Ziyauddin's *"Occupational Caste Groups' Illness and Health in India: Lessons from the Lives of Conservancy Workers"* (2025) is an ethnographic account that critically examines the relationship between caste-identity and access to healthcare in India. At the heart of the ethnography are the Hadis of Jharkhand, a Scheduled Caste community traditionally engaged in manual scavenging. Situated in the Hadi Cooli in the municipal town of Chas at Bokaro district, the study focuses on the perceptions of illness and the health-seeking practices among the Hadis. The monograph makes an ambitious claim as the first dedicated ethnographic study of the Hadis of Jharkhand, marking a clear departure from previous scholarship that largely focused on macro-analyses of dominant castes, leaving smaller sub-castes unexamined. Moving beyond simplistic economic analyses, the study illustrates how stigma and caste identity shape illness perception and healthcare resource utilisation.

Instead of treating illness as simply as a biological phenomenon, chapter one, foregrounds how 'perception' functions as a framework which determines how illness is socially constructed at familial and community levels. Perceptions determine how disease is to be navigated through and negotiated with, often creating an iceberg phenomenon where common symptoms such as joint pain, tiredness or headaches

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are not reported due to linguistic hierarchies in the clinical settings. Here the author uses '*iceberg phenomenon'* to describe a situation wherein clinically visible cases of a disease show or form merely a small proportion of the larger total cases, while a vast majority remain hidden and unseen in the community. Dismissal of Khortha terms such as *'tatainee'*, constant body pain; *'adhkapari'*, partial headache; *'karjawa-faet jaa hau'*, extreme pain and suffering; and, '*gaud-haath peera haua re'*, pain in the legs and arms, by biomedically trained doctors leads to institutional alienation and feelings of deep mistrust among the Hadis, forcing them to seek alternative solutions for their illness at medicine shops, traditional healers and quacks (p. 9). Such empirical findings corroborate those of Gopal Guru (2013), who argues that dominant forces inhibit Dalits' freedom of expression in public spheres, thereby creating a social ecology where Dalits' experience severe marginalisation (pp. 40-41). The chapter's significance lies in its challenge to the Parsonian model of the sick role (1951). The Parsonian framework (1951) of voluntary rest fails to capture the nuanced illness behaviour among the Hadis. The Hadis' hand-to-mouth existence prevents them from adopting the sick role until they are able to work. Moreover, adoption of the sick role is a gendered activity as Hadi women prioritise the health of the male breadwinners over themselves, producing inequalities within the caste-group.

The second chapter highlights the severe material constraints that the Hadis face in their Cooli. Among the 22 Scheduled Castes in Jharkhand, as notified in the Census of India 2011, the Hadis are positioned at the bottom of the caste hierarchy. Historically, categorised as a sub-caste of the Methars, they have experienced systemic erasure of the Hadi identity through lack of government acknowledgement and routine misspelling of their names as Hair or Hari. The community dissociates itself from the government-imposed Hari identity and assert themselves as members of the Hadi Jati who trace their origin to the royal patronage of the Maharaja of Kashipur in erstwhile Purulia, West Bengal. The decline in the royal patronage during the British rule, along with the redrawing of geographical boundaries of states in post-Independent India, significantly impacted the lifeworld of the Hadis, who were forced to leave their occupations as royal caretakers and start cleaning nightsoil in the rapidly expanding Bokaro Steel Plant Township, a city under the government of India managed by a public sector unit. Cramped in small *Kutchha* or semi-permanent houses, without ventilation, electricity, and running water, the Hadis depend on small ponds near their neighbourhood for cooking, cleaning, and bathing. However, the drying up of ponds and lack of direct water pipelines to the Cooli disrupt such daily activities. Drinking water is procured through groundwater pumps, which the discussion claims contain significant quantities of metals and minerals which cause frequent stomach infections among the Hadis (pp. 72-80). Moreover, the lack of toilets exposes the Hadis to increased bacterial infections and socially undermines their dignity (p. 75). Fear and lack of awareness also pose as obstacles in the Hadis' path to claim government-

sponsored schemes and security benefits (p. 79). However, reliance on narratives and macro-level statistical data, such as the Census of India 2011, without actual water-quality testing poses a serious methodological limitation of the study.

Chapters three, four and five underscore the monograph's central argument by highlighting the tension in the Hadis' intersecting dual identities: first that of a patient seeking healthcare, and the second identity of a socioeconomically marginalised caste-group performing conservancy work (p. 96). These identities significantly impact their health-seeking practices and the relationships they establish to seek help. Brief consultations filled with indifference and lack of empathy; lack of doctors and medical facilities such as X-ray and MRI testing; high treatment costs compel Hadis to seek treatment from Registered Medical Practitioners (RMP) who are not biomedically trained doctors or visit the *davaee dukan* or the medicine shop. RMPs play an important role in the health-care seeking process as they are frontline healthcare providers across rural and urban settings (pp. 126-134). Unlike MBBS doctors, RMPs patiently listen to the Hadis and treat them at lower costs, hence strong bonds of trust are developed with the RMPs. While the Hadis perceive public and, to an extent, private hospitals as sites of caste discrimination and hostility, they perceive local medicine shops and RMP clinics with trust as they are treated with dignity despite their stigmatised occupational background. This directly translates into the popularity of *suya*, injections and *goli*, tablets among the Hadis as methods of cure (p. 156).

Chapter four formulates a three-stage model of health-care seeking behaviour among the Hadis. First, the Hadis attempt to manage pain and discomfort using home remedies. When home remedies fail, the Hadis seek help from over-the-counter drugs or golis at the local medicine shop. If *golis* fail to provide relief, the Hadis visit local RMP clinics where they seek to be administered a suya or injection which they believe can cure prolonged illness without having to spend money on further investigations such as blood tests, X-rays and hospitalisation. Trust and dependence on injections are shaped by economic constraints (p. 159). Getting an injection quickly soothes bodily pain and helps Hadis return to work or continue working without losing daily wages. Similar reliance on informal healthcare agents is observed during childbirth as well. The cost of delivery at nursing homes is significantly high, rendering it inaccessible to the Hadis. Therefore, the Hadis rely on home births assisted by a Dai or female birth attendant. These attendants usually belong to the Bauri community and lack formal training to deal with post-natal complications. However, they remain a critical part of the Hadi woman's support system across generations due to a lack of resources to afford better health care services. The chapter provides critical insights into health cultures and their vital role in the community's overall culture, which often shapes them (p. 179).

Based on a multi-sited analysis of the Hadis' interactions and encounters at four distinct healthcare locations: public health institutions such as public hospitals and

health centres; private clinics of qualified doctors; traditional healers; and local RMP clinics (pp. 185-204), limited medical facilities, shortage of drugs, absenteeism among government doctors (p. 185), inflexible OPD timings emerge as common problems that the Hadis face. As a result, the Hadis are compelled to frequent the shrines of Ojhas and Tantrik Babas (traditional healers) and the RMP clinics to seek treatment (p. 201) and find immediate relief.

Chapter six condenses the monograph's empirical findings into policy recommendations. Based on the empirical findings, the author advocates for four primary changes – increased administrative sensitisation, restructuring and flexibilization of OPD timings to accommodate daily wage earners, increased civil entitlements such as the construction of water pipelines and toilets in the Hadi Cooli; lastly, increased availability of biomedically trained doctors and quality medical amenities at public hospitals and healthcare centres to render medical treatment accessible to all sections of the Indian population. However, a slight dissonance emerges in his recommendations. The core of the argument primarily emphasises the need to strengthen the formal biomedical healthcare system, but Chapters two to five highlight how informal healthcare professionals provide the greatest healthcare support for the Hadis. By focusing solely on the formal healthcare system, the monograph does not consider the futures of informal healthcare professionals or how they can be integrated into a formalised structure.

Earlier scholarship on sanitation work, from Shyamlal's (1984) ethnography on the Bhangis to more contemporary studies on the impact of caste on spatial segregation and cultural marginalisation (Guru, 2013; Jodhka, 2018), has primarily examined the socio-economic inequalities associated with caste-based occupations. However, Ziyauddin's monograph moves beyond this traditionalist perspective and foregrounds the biopolitical dimensions of manual scavenging, highlighting how structural inequalities enable distinct health risks. In consonance with Jodhka (2018), the monograph examines how modernisation as a social force reproduces caste inequalities. In the modernising landscape of Bokaro, the Hadis' body emerges as an archive of historical caste-based oppression, bearing evidence of inter-generational occupational marginalisation and structural exclusion.

The monograph makes an important contribution to the field of medical sociology by addressing a significant gap in the literature on the sick role. Unlike the Parsonian model of the sick role (1951), Ziyauddin observed that the performance of the sick role is considered a hindrance in the Hadis and is delayed for as long as possible. Additionally, the performance of the sick role, as he highlights, is a gendered construct. Women rarely adopt the sick role, thereby creating an intra-caste hierarchy which favours earning male populations to seek health-care facilities, followed by the young and the old, and lastly the women. Ziyauddin's work does not engage deeply with the gendered dimensions of the sick role. By treating women's reluctance to prioritise their own health as an economic decision, the monograph underexplores

the distinct and layered sufferings of women. However, his work remains significant because it not only highlights health inequalities across caste groups but also within intra-caste settings.

The monograph focuses only on a single community of manual scavengers in a regionally specific location. The study's analysis may be limited in scope, preventing a holistic picture of healthcare conditions among Dalits across the nation. Moreover, a comparative study with other communities of conservancy workers could reveal the cultural similarities and differences among various caste groups, thereby producing a more enriching account of the socioeconomic conditions and health-seeking behaviour of these groups within the state of Jharkhand.

Based on employment patterns, the Hadis constitute a unique case. Unlike the majority of India, where women predominantly work as sanitation workers (Kumar and Preet, 2020), in the Hadi community of Bokaro, men are primarily involved in sanitation work. This gendered division of labour remains underexplored in Ziyauddin's work. The monograph does not address why Hadi women are less visible in formal sanitation work – whether it is due to patriarchal notions within the community that restrict women's entry into the public sphere, or whether employers prefer males over females. As a result, the study can be critiqued for its limited ability to capture the Hadi women's lifeworld and everyday life perceptions.

In spite of these limitations, the book illustrates how illness is deeply constructed through caste-based occupational association of communities and how caste identity actually navigates the lifeworld of oppressed caste groups. Therefore, the book is a timely intervention, highlighting the dearth of ethnographic attention to marginalised sub-castes and offering critical methodological insights on future studies on caste in contemporary India.

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