

Differences in Access to Health Resources: An Analysis of Disparities among Dalit Sub-castes in Uttar Pradesh, India

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Abstract

This essay is based on an empirical study conducted in Sonbhadra district of Uttar Pradesh. It argues for the need of sub-caste level analysis among Dalits as regards their access to health resources. Making use of both quantitative and qualitative data, the disparities in the socio-economic standing of various sub-castes within scheduled castes are discussed. The perceptions about health, illness and disease provides the contextual information about the prevalence of various health conditions while the concentration curves reflect the disparities in out-of pocket expenditure, landholding and income among various sub-castes within Dalits. The case reports of the respondents facilitate an understanding of the intersection of social identity, economic status and spatial inaccessibility of health services as barriers in accessing health care services. The essay suggests that the differences in access to health resources among various sub-caste of Dalits is a function of intersection of social identity, socio-economic status and geographic location of health care services. There is a greater need to identify the differences and challenges within sub-castes to overcome the gap between their health needs and accessibility of health care services.

Keywords

Caste, social stratification, social identity, access to health care services

Introduction

It is widely acknowledged that socio-economic inequities shape people's experiences of health and their access to care services. The commission on Social Determinants of Health report (2008) has been a milestone document as regards the shift in understanding

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about health and health inequalities. It drew attention to the bi-directional relationship between health and social environment. The social environment or social determinants of health vary across and within countries as per the context.

Caste is one of the important social determinants of health in the Indian context. Quite often, it intersects with other structural inequalities and shapes people's experience of health and access to health care services. It plays an important role in constituting the social environment as caste status mostly determines whether people get ample opportunities to get educated, are gainfully employed or lead a life of dignity, and consequently, healthy and fulfilling lives.

Caste-based hierarchical structure of Indian society creates unequal spaces for different social groups. Caste exhibits a level of differentiation, which is frequently visible in terms of norms, values, culture, disabilities, discriminations and social restrictions of varied nature to govern the society. Social stratification is a social hierarchy of social differences implying that Indian society is divided into caste and sub-castes. It is one of the social institutions prevailing in India since time immemorial (Gupta, 1991; Mukherji, 1999; Sharma, 2007; Beteille, 2013).

Various studies also highlight that caste-based discrimination leads to poverty and material deprivation among Dalits.¹ The differences in socio-economic status among different social groups is also a function of the caste-based discrimination and deprivation. These multiple deprivations also create developmental deficit in their social life (Haan, 1997; Thorat and Deshpande, 2001; Shah, 2002; Nayar, 2007).

Even after seventy-five years of independence and despite the provision of constitutional safeguards, Dalits face discrimination in social, economic, health, and political spheres. Indian society is a caste society and most economic, political, educational and socio-cultural activities or opportunities revolve around the idea of caste. Due to the ongoing injustice and lack of equal opportunities, SCs and STs occupy the lowest ranks in society nationwide. The extent of suffering, however, varies from region to region, caste to caste, and even within a sub-caste across the country.

In the health sphere too, Dalits have limited access to nutrition and health services because of their poverty, illiteracy, low educational attainment, and discriminatory practices in accessing the health services. Borooah (2010) argues that people's health outcomes are influenced by their social group and there is a 'social gradient' in health outcomes in India. Some studies also note that as compared to non-Dalits, the utilization of health services are lower among Dalits (Ram et al., 1998; Kulkarni and Baraik, 2003; Baru et al., 2010). Acharya (2007) drew attention to the varying degrees

¹Dalit is the word chosen by the castes at the bottom of Indian social hierarchy to describe them. It does not figure in the Indian constitution at all. It is the term asserting identity and unity. In the constitutional parlance and Govt. of India documents use the term "Scheduled Castes" (SCs) over Dalits.

of discrimination among Dalits in accessing health services in the states of Gujarat and Rajasthan. The National Family Health Survey (NFHS) also found that there is a significant difference between the Scheduled Caste and non-Scheduled on various health indicators.

In India, large-scale surveys such as NFHS, NSSO and IHDS mainly focus on inter-group inequalities. Using the NFHS data, Deshpande (2001) constructed caste deprivation index and exhibited regional variation in inter caste disparities in India. Several studies have used secondary data from these large-scale datasets to reflect inter caste inequalities in access to health services, health outcomes and utilization of health care (Baru et al., 2010; George, 2015; Shaikh et al., 2018; Bansod et al., 2022). These studies have clearly enhanced our understanding about differences in health indicators, access and utilization of health care services across social groups.

Since, the analysis of data from these large scale datasets rarely go beyond social groups, the intra-caste level inequalities mostly remain uncaptured/hidden. The micro-level studies or studies with statistical simulation or counterfactual study designs attempt at predicting the associations between variables (Goli, Doshi & Perianayagam, 2013) or within group inequalities (Deshpande, 2000; Goli, Maurya & Sharma, 2015). Still, there have hardly been any primary studies that acknowledge and explore the intra caste inequalities among Dalits with respect to access to economic and health resources. This essay attempts at mapping differences among sub-castes of Dalits while accessing the health services in the rural villages of Sonbhadra district of Uttar Pradesh. It also attempts at exploring the factors that restrict their access to health services and how their socio-economic status, primarily a function of their caste status, acts as a barrier.

The caste-based social inequalities and multiple levels of deprivation have been operational since time immemorial and have not only resulted in the inter group inequities in access of health services but also lead to intra group inequalities among various sub-castes of Dalits. George (2015) also argues that it is important to take sub-castes as analytical categories because discrimination is gradual even within the same *Jati*-based social group. Further, differences in health status within social groups are often a function of intersections of identity differences between subgroups of population based on their sub-caste, class, gender, economic or geographic characteristics.

Social group health indicators are summary measures of subgroups of the population, and as such, they masquerade part of the inequality in the population (Murry, Gakiduo & Frenk, 1999). The large-scale data though helpful in understanding the population or inter-group level analysis, does not give a nuanced understanding of differences at the individual-level characteristics and their intersections such as age, sex, education, caste and sub-caste status, social network, occupation and social

capital. The primary studies, on the other hand, may not be very helpful in drawing generalizations but have the potential to capture the specifics of contexts and causal mechanisms required to understand a specific research question.

Objectives

The main focus of the study was to understand the plausible factors for differences in accessing health resources among the sub-castes of selected Scheduled Castes. The objectives of the study included:

- i. To understand the health perception and the structural factors that shape the health seeking behaviour.
- ii. To contextualise the determinants of differences in access to health resources in the socio-economic standings of various sub-caste among Dalits.
- iii. To understand the barriers in access and utilization of health resources.

Data

The study was conducted in two villages of Sonbhadra district, Uttar Pradesh. The selection of villages was based on the composite index (on social amenities and social facilities), developed by using the District Census Hand Book (DCHB),² Census of India 2011. However, for the purpose of this essay, to facilitate an in-depth analysis of selected scheduled castes and their sub-castes, we are using data from one of the selected villages.

Two Scheduled Castes, namely, Chamar and Dharkar were selected. These two castes had a sufficient number of sub-caste households in the village. A total of 200 households were selected. The three reported sub-castes among Chamars included Chamar, Ravidassia Chamar and Dhusiya Chamar while those from Dharkar caste reported four sub-castes namely, Benbansi, Bansphor, Lakharhara and Kharush. A total of thirty households from each sub-caste were selected except for Kharush where only twenty households were selected for the study.

Method

The study uses a mixed method approach. The household data was collected using household interview schedule. Further, in-depth interviews and group discussions were carried out with the selected respondents. The qualitative data reflects the health perceptions of research participants, health seeking behaviour and the factors that

²The District Census Hand Book (DCHB), Census of India provides data at the village level for demographic and socio-economic characteristics of the population and gives information on civic amenities and social facilities. It gives information about the availability of educational and health facilities, drinking water, post office and telegraph services, communication, bank and credit societies, and recreational facilities etc.

shape the health seeking behaviour. The concentration curves are plotted for various sub-castes to reflect inequality in income, land ownership and out-pocket expenditure on health. The narratives from the research participants are integrated to contextualise the findings from the concentration curves.

Findings

This section discusses the perceptions about health and ill-health as reported by the participants. The nature and patterns of diseases and preferences of treatment among various sub-castes are also reported. However, following the sociological approach, as suggested by Keleher and Murphy (2004), the notions about health and ill-health are contextualised in social, political, economic and structural dimensions. Thus, understanding of health is broadly recognized by the range of social, economic, cultural and environmental factors which give an idea of understanding health in terms of people's capacity to have access to resources that they need to be healthy, and to adapt, respond to or control the challenges and changes in the environment that surrounds them.

Perceptions about Health

The most cited response for the perception about health, as regards the frequency was in the form of the absence of disease. One of the respondents from Chamar sub-caste shared perception about health as: 'One who is not suffering from any disease and does not feel any weakness while engaging in any kind of work is healthy.' (N, 38 years, Chamar sub-caste).

A female respondent from the Dhusiya sub-caste shared her perception about health as the absence of any ailment and ability to perform day-to-day activities without feeling tired as follows:

I often feel very tired. I face many difficulties managing all the household chores. Also, several other tasks such as collecting firewood and fetching water make me extremely tired. I do not consider myself healthy, as I feel tired all the time. Being healthy means someone who does not feel tired, can work without any ailments. (R, 42 years, Housewife)

Thus, though different respondents reported their varied perceptions about health, most respondents perceived health as 'a condition devoid of any disease or bodily discomfort'. The ability to carry out their everyday activities without any pain or discomfort was also frequently reported as a state of being healthy.

Perceptions about Ill-health

Ill-health was identified as illness or disease and the two were perceived to affect the bodily function and, consequently, the state of health. The distinction between the illness and disease was based on the perceived severity, duration and the expenditure incurred to cure a condition. 'Illness' was largely perceived to encompass minor

diseases which could be treated without accessing medical facilities. The ‘disease’, on the other hand, was identified as a major ailment and required medical attention. Further, some serious conditions of diseases were even perceived to be fatal.

The most reported illnesses among various sub-castes in the selected village included headache, body ache, joint pain, itching, fever and cold-cough. There were, however, differences in the prevalence of a specific illness among households belonging to a particular sub-caste. Hence, the respondents reported certain health problems that affected their family members frequently. For instance, the respondents belonging to the Lakarhara sub-caste whose occupation included working in the forest area attributed itching and skin-related problems largely to their work environment. Thus, the respondents often traced the causation of illness to their natural or work environment.

Patterns of Diseases

The health profiling suggested prevalence of malaria, diarrhoea, tuberculosis, jaundice and kidney stone among the study population. However, the prevalence of certain diseases such as diarrhoea, jaundice and kidney stone was higher among the Chamar and Ravidasiya Chamar. The participants from Dhusiya sub-caste also suffered from these ailments but the prevalence of diarrhoea was highest among them compared to other sub-castes of Chamars. Among the Dharkars, snakebite, diarrhoea and complications arising from the consumption of local liquor were frequently reported. As regards the higher incidence of snakebite among Dharkars, since their work requires them to visit forest and the same may be responsible for higher incidence of snakebite.

Complications arising from consumption of local liquor and snakebite were also reported as some of the most common causes of death in the study village. Among women, death during childbirth was also frequently reported. Many respondents reported that the lack of health infrastructure in the village that could handle complications during pregnancy and childbirth was one of the reasons for higher incidence of death among pregnant women.

Determinants of Differences in Differential Access to Health Services

As discussed earlier, there are differences in access to health services across the two Dalit sub-castes. An attempt is made to understand these differences from the vantage point of their socio-economic standing, quite often a manifestation of their caste status, income and landholding status. This section discusses the disparities in out-of-pocket health expenditure, landholding and monthly household income within each of the selected castes.

Out-of-pocket Health Expenditure

The data on out-of-pocket health expenditure is plotted along a concentration curve and reflects the inequality in expenditure within the two sub-castes (Figure 1 and Figure 2). The same substantiates the findings from the qualitative data discussed above.

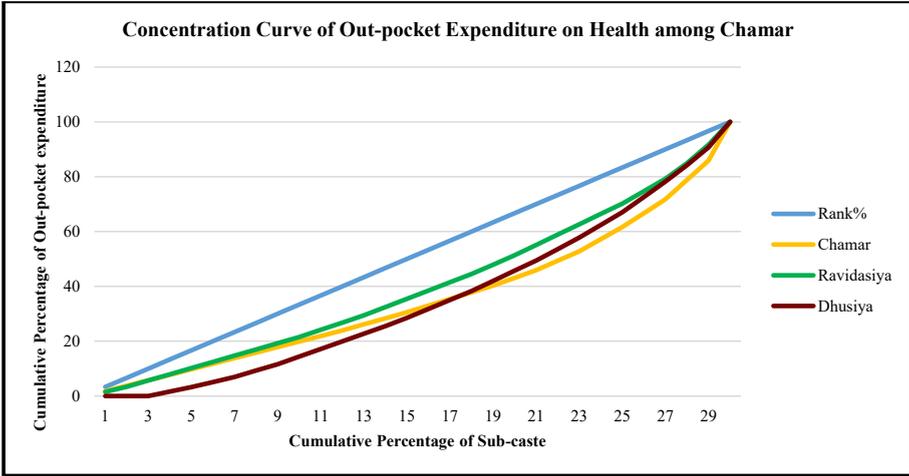


Figure 1: Out of pocket expenditure on health among Chamars

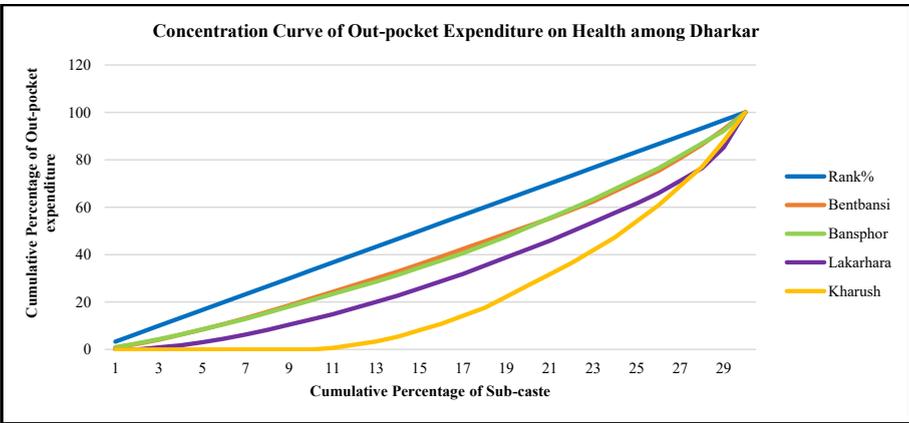


Figure 2: Out of pocket expenditure on health among Dharkars

Landholding Status

Figure 3 indicates the landholding status among respondents from different sub-castes of Chamar caste. The disparity in this suggests that none of the respondents from Chamar sub-caste reported being landless while some of the respondents from Ravidasiya and Dhusiya sub-caste had no land. The selected village came under the Ambedkar Gram Vikas Yojana (AGVY) initiated by the Bhaujan Samaj Party (BSP) government and at that time, land was leased to the landless households. Therefore,

most of the respondents from Chamar sub-caste had the land. One respondent, aged 42-years, drew attention to government initiatives, through which those belonging to the Scheduled Castes could get land on *Patta*. Acquiring land on *Patta* led to a change in the traditional caste-based occupations. It transformed the pattern of primary occupation among the Dalits who could then also engage in cultivation. Eventually, their economic situation improved, and they could even purchase a small amount of land. As regards the landholding, very few respondents (from the Chamar caste (about 3.3 per cent) owned land. Similarly, Figure 4 shows the inequality in landholding status among various sub-castes of Dharkars. When compared to Chamars, the inequality within various sub-castes of Dharkars is more stark.

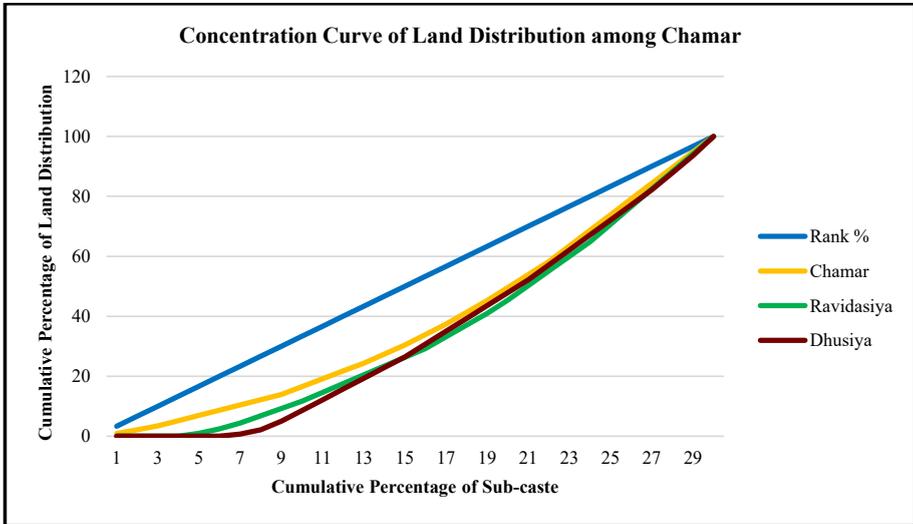


Figure 3: Land Distribution and Sub-caste level differences among Chamars

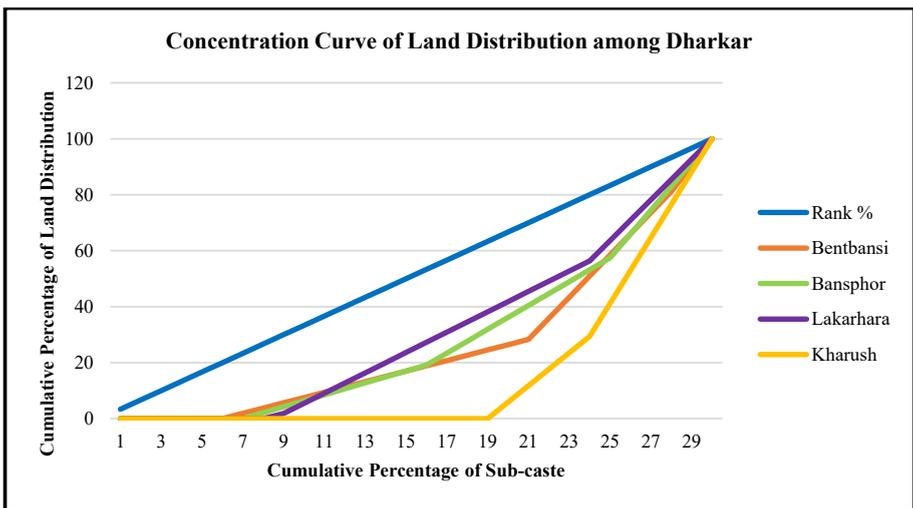


Figure 4: Land Distribution and Sub-caste level differences among Dharkars

Table 1 also reflects that all the Chamar sub-caste households had some land while landlessness was still prevalent among other sub-castes of Chamar. The landlessness was more prevalent among those belonging to Dharkar caste. Even among those who hand some land on lease, stark differences could be observed across various sub-castes. Sub-Caste based differences in landholding suggest that the differences within scheduled castes must also be acknowledged and efforts are required for their upliftment.

Table 1: Distribution of land ownership by caste and sub-caste

Sub-caste/ caste	Nature of land ownership						Total number (%)
	Landless	Leased	Patta	Owned	P+L	P+O	
Chamar	--	07 (23.3)	--	02 (6.7)	13 (43.3)	08 (26.7)	30 (100)
Ravidasiya	04 (13.3)	02 (6.7)	10 (33.3)	--	08 (26.7)	06 (20)	30 (100)
Dhusiya	06 (20)	01 (3.3)	10 (33.3)	01 (3.3)	07 (23.3)	05 (16.7)	30 (100)
Total Chamar	10 (11)	10 (11)	20 (22)	03 (3.3)	28 (30.8)	19 (20.9)	90 (100)
Bentbansi	06 (20)	15 (50)	--	--	07 (23.3)	02 (6.7)	30 (100)
Bansphor	07 (23.3)	09 (30)	09 (30)	--	05 (16.7)	--	30 (100)
Lakarhara	08 (26.7)	01 (3.3)	15 (50)	--	06 (20)	--	30 (100)
Kharush	09 (45)	05 (25)	06 (30)	--	--	--	20 (100)
Total Dharkar	30 (27.3)	30(27.3)	30(27.3)	--	18(16.36)	02 (1.7)	110(100)

Income

The respondents from Chamar and Ravidasiya sub-castes had monthly household income in the range of ₹ 6,000-10,000 and they were mainly involved in cultivation or agricultural labour. The monthly household income of respondents from Dhusiya sub-caste was found to be between ₹ 5,000-8,000/-. They were mostly engaged in agriculture and daily wage labour and invariably respondents from all Dhusiya households pursued pig farming. This occupation was important for their economic mobility but the same was not considered a 'clean' occupation. Those from the Chamar and Ravidasiya sub-castes often ridiculed them for engagement in pig farming and living in unclean environment. Dhusiya were, thus, considered as lowest among the Chamar caste.

The concentration curve of the household income among sub-castes of Chamar caste is plotted as Figure 5. It shows the disparity in income among various sub-castes of Chamar caste. Figure 6 reflects the differences within sub-castes of Dharkar caste as regards the monthly household income. The income range of Bansphor is better when compared to other sub-castes among Dharkars. The relatively higher monthly household income of Bansphor is due to their occupational engagement as bamboo basket weavers and almost all family members in the household were engaged in the occupation. Among respondents from Bentbansi and Lakarhara, not all the household members were engaged in any economic activity.

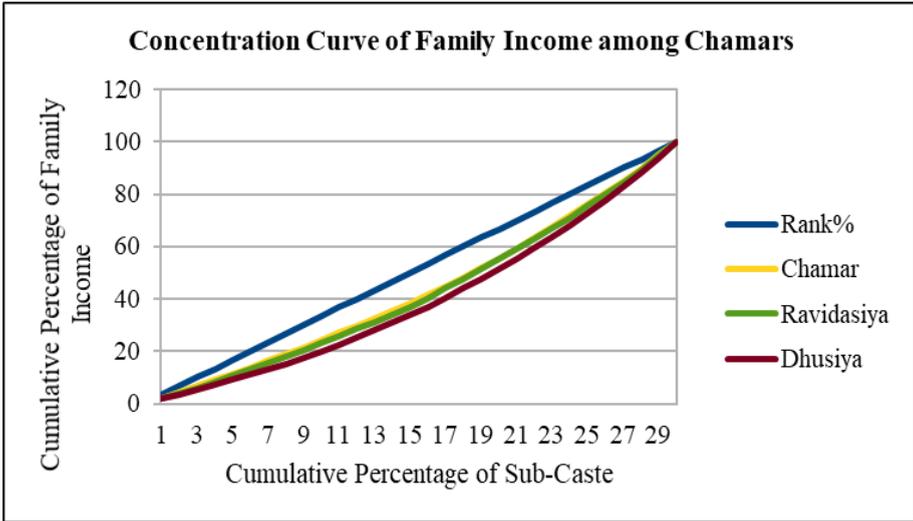


Figure 5: Concentration curve of HH Income of Chamar caste

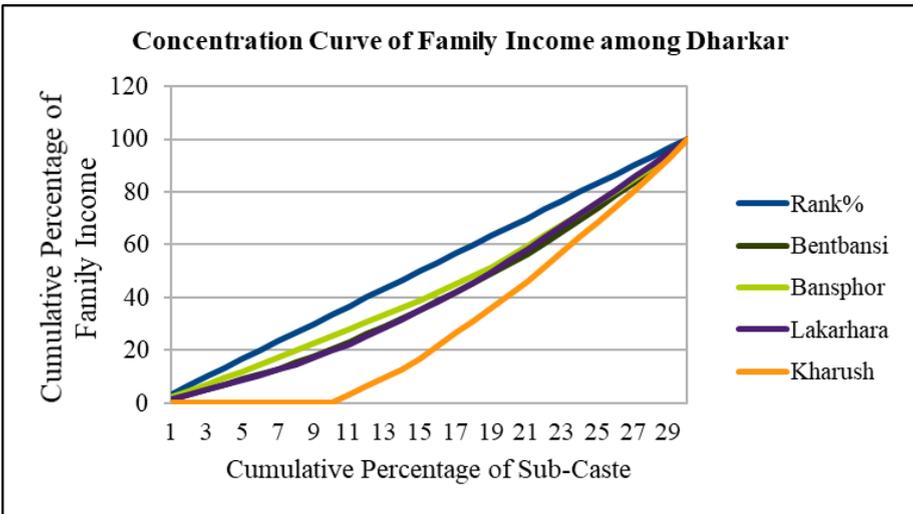


Figure 6: Concentration curve of HH Income of Dharkar caste

Barriers to Access and Utilization of Health Resources

As discussed earlier, the severity of health conditions determined whether the research participants considered a specific health condition worthy of medical attention. Home remedies and alternative treatment methods such as approaching traditional healers were the most preferred treatment methods. The participants approached medical facilities only if these most readily and economic courses of treatment proved

ineffective. Some of the case reports from the field elucidate this pattern for various health conditions as follows:

The Course of Treatment for Malaria

U, a 45-year-old woman from the Lakarhara sub-caste with a monthly household income of ₹ 7,000 reported that her husband suffered from malaria and could not survive. She narrated the course of cure as:

My husband had returned from the forest and complained that his body ached badly. He even had a fever and felt very weak. As soon as he returned from work, he told that he needed to go to the healer in the village. He returned with some herbal powder and had that with water. He waited for a day. Since he could not get any relief, he then went to the doctor (without any medical education and training) in the village. The doctor gave him some tablets. He did not get any relief even after taking medicine. But we hoped and wished that his condition might improve. After waiting for two days, we could see that his situation was getting worse than before. He could barely walk and shivered all the time. It was then that we (she and her elder son) decided to take him to the private hospital at Myorpur. My son took him to the hospital by a bicycle. The doctor there gave him 2-3 injections and sent back home. The same night he passed away. The entire course of treatment came to be around ₹ 2,000-3,000, and still, my husband could not be saved.

In the above narrative, we find that the course of treatment ranged from a traditional healer to the private hospital. Subsequently, the cost of treatment also varied from a minimal amount to almost half the amount of monthly income of the given household. The delay in availing a treatment from the private hospital also indicates that the economic burden of treatment from a private facility was avoided by seeking alternative resorts to treatment. The given case also highlights that since there was no government health facility in the village, the residents had to rely on whatever health resources were available in their close vicinity.

A similar pattern of resort to cure was observed among respondents from Chamar sub-castes. And they also resorted to cure at the level of the village itself. Even those who were relatively well-off and belonged to the socially dominant sub-caste accessed private health care services in the event of the severity of the disease. It is thus evident that the accessibility of health services emerges as a crucial factor in shaping the course of health care. It is, however, to be noted that households belonging to sub-castes with better socio-economic standing and conveyance had a relative advantage of accessibility to healthcare services situated at a distance compared to those without means.

The Course of Treatment for the Ill-effects of Consumption of Local Liquor

The consumption of local liquor was observed to be high in the selected village. However, the respondents from the Dharkar caste reported the ill-effects of

local liquor consumption as most severe among other diseases. One of the key respondents even shared that there have been instances of death resulting from the consumption of local liquor.

G, a respondent aged 52-years from the Dharkar caste and Bentbansi sub-caste informed that his 29-year-old son frequently consumed local liquor and would often fall sick. The local doctor was frequently approached for the treatment who in turn would inject saline into his blood to cure him. However, in one such instance, he was extremely sick. The local doctor was also scared of his condition. He refused to provide any treatment and asked them to take him to the town. Though it was very late at night, they immediately took him to a private hospital at Myorpur. The doctor at the private hospital got him admitted. He stayed at the hospital for two days after which he was discharged. The reported cost of treatment at the hospital came to be around ₹ 4,000.

Since the respondent belonged to the Bentbansi sub-caste among the Dharkars, he could take his son to a distant health facility via a personal conveyance and also spend an amount close to ₹ 4000 for the treatment. Here, it should be noted that the economic disparities across and within sub-castes differentially shape the choices regarding the course of cure. One of the households from the Bentbansi sub-caste who did not have money and other means for the treatment of ill-effects of the local liquor reported the loss of life of one of their male members.

Care During Pregnancy and Childbirth

There were no health facilities in the village that could cater to the needs of pregnant women. Specifically, many women reported the need for health facilities in the village that could handle complications during pregnancy and childbirth. There were also instances of death of pregnant women during the childbirth as follows:

N, a 47-year-old respondent belonging to the Dhusiya sub-caste with a monthly household income of ₹ 7000 shared how her daughter-in-law lost her life during the childbirth as follows:

R was 19 years old at the time of her first pregnancy. She was pregnant by nine months. She suffered from pain in the stomach and called me for help. I rushed and brought Dai along with me. Dai examined R and told that she could not handle her case. R was crying in pain and was taken to CHC Myorpur, where no doctors were available at night. In such a situation, we took her to a private hospital called Nath Nursing Home where she was operated after that. She delivered a child but the doctors could not save the mother. We were asked to pay ₹ 4,000 as the cost of operation.

It is quite likely that the time required to travel to reach the CHC, unavailability of a doctor(s) at the CHC, and consequent shift to the private nursing home led to loss of time in getting the medical aid and led to the maternal death. The above case highlights

the loss of life of a woman during the childbirth primarily due to the lack of basic health facilities.

Access to Health Resources

The access to health resources, specifically the spatial accessibility of health care services appeared to be one of the major challenges in accessing health care. The poor socio-economic status of the research participants from certain sub-castes exacerbated the challenge. Some of the participants from certain sub-castes such as Chamars who owned a conveyance could manage to reach a public or private health facility situated at a distance of 10–15 km from the village. Those from Dhusiya sub-caste and all the sub-castes of Dharkar with a relatively lower level of income lacked means to avail these health care facilities and if at all, they managed to access, they seemed to appear to have lost a lot of time trying to cure the ailment by other means that were far more economic and readily available at the village level. The time lost in accessing health care facilities situated at a distance also proved fatal at times. Table 2 shows the availability or non-availability of nature of health resources at the village level and the distance of various public and private health care facilities from the village.

Table 2: Nature and availability of health resources in the study village

Health Resources	Distance	Number
Community Health Centre, Primary Health Centre	10+ km	00
Maternity And Child Welfare Centre, Family Welfare Centre	5-10 km	00
Sub Centre, Hospital Allopathic, Hospital Alternative Medicine, Dispensary, Mobile Health Clinic	NA	00
ASHA	<5Km	01
Nutritional Centres-ICDS, Nutritional Centres-Anganwadis Centre,	Within village	01
**-. Healer, Local Doctor (Bengali Doctor)	Within village	02

** Resources reported during the fieldwork

Table 2 shows that most healthcare institutes are situated far away from the selected village and the respondents often reported challenges in accessing these health resources.

The primary health centre and community health centre (Myorpur) were situated at distance of more than 20 km. Some of the respondents from Chamar and Ravidasiya sub-caste reported that they were able to reach CHC Myorpur during any health emergency or complication during pregnancy and childbirth since they had their own vehicle. The district Hospital at Robertsganj was also more than 100 km away and the same posed a challenge in access to health care services. A private hospital was located in Dudhhi at a distance of about 40 km. The respondents reported accessing the same if they were referred from the government hospital. However, few of them could afford the expenditure at this private facility. One of the Dhusiya Chamar respondents shared that his family member was admitted to a private hospital after consuming the

local liquor. However, he did not survive as they took a lot of time in taking a decision whether to take him to this private hospital.

As mentioned earlier, accessing public or private health facilities was more challenging among the respondents from the Dharkar caste. Many people from Dharkar caste lost lives due to complications arising from consumption of local liquor. Not only the distance of health services but also their poor economic condition constrained their access to health services. The unavailability of injections to cure snakebite at the public health facilities was also reported as a reason for death among some of the respondents from Lakarhara sub-caste. Some of the respondents even reported that they felt there was no value of their life.

Some of the respondents from Dharkar caste also reported visiting charitable hospitals located at Renukut in Sonbhadra district, Uttar Pradesh and Singrauli (Madhya Pradesh). The respondents reported visiting these hospitals for operations to remove kidney stones and to get treatment for fractures of bones. Since they did not have to spend any charges on the treatment at these hospitals, they preferred visiting the same over private hospitals which were not at all affordable. However, even to visit these charitable hospitals, the respondents had to manage to arrange for the travel cost, which was certainly far lower than the treatment cost at private hospitals.

It appears that the population in the selected villages were deprived of basic healthcare services owing to unequal development. Further, various sub-castes among Dalits experienced varying levels of marginalization as per their socio-economic status, mostly an outcome of being trapped in the caste system and its interaction with other inequalities manifesting in caste-based occupations, landlessness and consequent poverty.

Discussion

This essay discusses the differences in access to health resources among the sub-castes of selected scheduled castes in the study village. It attempts to reflect the intersections of caste identity, socio-economic standing and spatial accessibility of health resources as determinants of differential access to health resources. Most of the studies in access and utilization of health care services compare the differences across social groups. This study attempts to draw attention towards the differences within already marginalised social groups. The sub-caste level analysis reflects the heterogeneity and challenges specific to certain sub-castes within selected Dalit castes.

There is a greater need to acknowledge the disparities within scheduled castes so that they are not 'left behind'. Despite the constitutional safeguards, the historical injustice against Dalits seems to continue. The same gets reflected in higher levels of illiteracy, engagement in caste-based occupations, and lack of opportunities to make strategic choices for socio-economic mobility. There have been certain sub-castes within scheduled castes that have been able to climb the socio-economic ladder to a certain extent. The intersectionality acts both as a challenge and enabler as per the context.

The essay suggests that there is a clear gap between the health needs of the study population and spatial accessibility of health care services. This gap is wider for respondents from certain sub-castes as their socio-economic standing further inhibits their access to health care services. The out-of-pocket expenditure during health emergencies pushes those from a certain sub-caste further down the vicious cycle of poverty and underdevelopment. In order to have a just and equitable society, it is important that the needs and challenges of the most marginalised are identified. This essay is a humble attempt towards reflecting the challenges of certain sub-castes among Dalits in access to health resources.

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